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No.

IN THE

Supreme Court of the United States

OCTOBER TERM, 1988

JAMES A. GORDON, Special Deputy State Insurance Commissioner of Maryland and Receiver for Eastern Indemnity Company of Maryland,

Petitioner,

v.

UNITED STATES DEPARTMENT OF THE TREASURY, *et al.*,

Respondents.

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FOURTH CIRCUIT

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QUESTIONS PRESENTED

The Maryland Insurance Code regulates the affairs of insolvent insurance companies and establishes a system in which priority is given to payment of policy beneficiary claims on a pro-rata basis. Inconsistently, 31 U.S.C. § 3713 provides that debts owed to the United States Government as a claimant by insolvent entities are to be paid ahead of all other debts. The McCarran-Ferguson Act, 15 U.S.C. § 1011 *et seq.*, provides that the business of insurance shall be regulated by the states and that no act of Congress shall be construed to invalidate, impair or supersede any state law regulating the business of insurance.

The questions presented are:

1. Whether the McCarran-Ferguson Act requires that payment of policy beneficiary claims against an insolvent insurance company be governed by state insurance code provisions regulating the liquidation of an insolvent insurance company and requiring pro-rata payment of policy beneficiary claims against that company, including those of the United States Government, notwithstanding 31 U.S.C. § 3713, which purports to give the federal government a priority over similarly situated claimants?

2. Whether provisions of a state insurance code regulating the winding up of an insolvent insurance company's affairs and the payment of policyholder claims against that company is conduct of the "business of insurance" for purposes of the McCarran-Ferguson Act?

LIST OF PARTIES

The parties to the proceedings below were Petitioner, James A. Gordon, Special Deputy State Insurance Commissioner of Maryland and Receiver for Eastern Indemnity Company of Maryland in Liquidation, and Respondents, United States Department of the Treasury and W.E. Douglas, Commissioner, United States Department of the Treasury, Fiscal Service.

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UNITED STATES DEPARTMENT OF THE TREASURY, *et al.*,

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PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FOURTH CIRCUIT

Petitioner James A. Gordon, Special Deputy State Insurance Commissioner of Maryland and Receiver for Eastern Indemnity Company of Maryland, respectfully prays that a writ of certiorari issue to review the opinion of the United States Court of Appeals for the Fourth Circuit, entered in the above-entitled proceeding on May 20, 1988.

OPINIONS BELOW

The decision of the United States Court of Appeals for the Fourth Circuit is reported at 846 F.2d 272 (4th Cir. 1988), and is reprinted in the appendix hereto, commencing at 1a.

The decision of the United States District Court for the District of Maryland is reported at 668 F. Supp. 483 (D. Md. 1987), and is reprinted in the appendix hereto, commencing at 6a.

JURISDICTION

Invoking federal jurisdiction under 28 U.S.C. §§ 1331(a), 2201-2202; and 5 U.S.C. § 701 *et seq.*, Petitioner brought this suit in the United States District Court for the District of Maryland. On August 31, 1987, the district court denied Petitioner's motion for summary judgment, and granted Respondents' motion for summary judgment. *See infra* at 22a.

Petitioner appealed, and on May 20, 1988, the United States Court of Appeals for the Fourth Circuit entered a judgment and opinion affirming the order of the district court. *See infra* at 5a. No petition for rehearing was sought.

The jurisdiction of this Court to review the judgment of the United States Court of Appeals for the Fourth Circuit is invoked pursuant to 28 U.S.C. § 1254(1).

STATUTES INVOLVED

1. 15 U.S.C. § 1011 *et seq.*, the McCarran-Ferguson Act (reprinted in full commencing at 23a).

2. 31 U.S.C. § 3713, Priority of Government Claims (reprinted in full commencing at 24a).

3. Md. Ann. Code art. 48A, § 132 *et seq.*, Rehabilitation and Liquidation (reprinted in full commencing at 25a).

4. Md. Ann. Code art. 48A, § 504 *et seq.*, Property and Casualty Insurance Guaranty Corporation (reprinted in full commencing at 53a).

STATEMENT OF THE CASE

A. The History Of Eastern Indemnity Company Of Maryland

Petitioner is a Special Deputy State Insurance Commissioner of Maryland ("the Special Deputy State Insurance Commissioner"), with powers derived directly from the Maryland Insurance Code. Md. Ann. Code art. 48A, §§ 133(5), 145. He holds this position by virtue of his appointment under Maryland law as the receiver for Eastern Indemnity Company of Maryland ("Eastern Indemnity"), an insurance company organized under the laws of Maryland and formerly doing business in more than 30 states.[1]

Although its chief line of business was issuing surety and fidelity bonds, Eastern Indemnity also wrote performance and payment bonds for construction projects, including "Miller Act" bonds for federal construction. *See* 40 U.S.C. § 270(a)-(e). Following an investigation launched in late 1984, the State of Maryland Insurance Division concluded that Eastern Indemnity's financial condition was dangerous to its policyholders and the public. Accordingly, the State initiated "delinquency proceedings" against the insurer pursuant to the Maryland Insurance Code. After a failed rehabilitation attempt, Eastern Indemnity was

[1] Because the liquidation of insurance companies is excluded from coverage under federal bankruptcy law, 11 U.S.C. § 109(b), the liquidation of insolvent insurance companies, as with other aspects of insurance regulation, has been an area of state, not federal, concern.

placed into liquidation and declared insolvent in 1985. *See* Md. Ann. Code art. 48A, §§ 141-142, 161.

B. The Maryland Statutory Regime Regulating Insurance Companies

Consistent with the exclusion of insurance company insolvency from the federal bankruptcy provisions of title 11 of the United States Code, Maryland law vests the Special Deputy State Insurance Commissioner, as the receiver for Eastern Indemnity, with specific powers to govern Eastern Indemnity's affairs. These powers include marshalling the company's assets, adjusting policyholder claims against the company, and making payments in accordance with the priority of payment system established by the Maryland Insurance Code. Md. Ann. Code art. 48A, § 132 *et seq.* Specifically, the Maryland Insurance Code provides that priority of payment from the assets of the Eastern Indemnity receivership is given to claims of policyholders, beneficiaries and insureds on a pro-rata, equal treatment basis ahead of all other claims, except for those representing employee compensation claims not in excess of $500.00, expenses of administering the receivership, and tax claims. Md. Ann. Code art. 48A, §§ 158, 158A.

As of October 1986, when the instant litigation was filed, Eastern Indemnity's liabilities exceeded $68 million while the receivership assets totaled only $1 million. Because the receivership's liquidated assets were insufficient to pay in full all claims within each priority class, the Maryland Insurance Code required the Special Deputy State Insurance Commissioner to make only pro-rata payments to claimants.

The potential loss to Eastern Indemnity policyholders is somewhat mitigated by the existence of the

Maryland Property & Casualty Insurance Guaranty Corporation ("the PCIGC"), also a creature of the Maryland Insurance Code. The PCIGC is responsible for paying a limited class of "covered claims" arising out of Eastern Indemnity policies written for Maryland residents. Md. Ann. Code art. 48A, § 504 *et seq.* Similarly, guaranty associations in some of the other states in which Eastern Indemnity did business may be responsible for payment of "covered claims" against Eastern Indemnity for insurance written for their residents.

Guaranty associations, including the PCIGC, provide only partial protection for policyholders, however. Some guaranty associations entirely exclude surety claims from their protection, while other associations impose ceilings on the maximum amount of a claim which will be paid. Significantly, the Maryland Insurance Code provides that the PCIGC and all other guaranty associations are subrogated to the claims of the policyholders they pay. Accordingly, the PCIGC and the other guaranty associations have a claim against the assets of the Eastern Indemnity receivership on an equal priority with other policyholder claims. Md. Ann. Code art. 48A, § 158A.

After subtracting all claims even potentially covered by guaranty fund payments from Eastern Indemnity's liabilities, there remains more than $18 million in policyholder, beneficiary and insured claims as well as the subrogation claims of the guaranty associations which must be satisfied exclusively from the $1 million assets of the Eastern Indemnity receivership.

C. The United States' Demand For Priority Of Payment, Contrary To The Payment Regime Established By The Maryland Insurance Code

On March 20, 1985, shortly after Eastern Indemnity was declared insolvent, Respondent, the Commissioner of the United States Department of the Treasury's Financial Management Service Office, asserted, on behalf of the United States and all of its "departments, agencies and instrumentalities and their contractors," a priority for payment of the federal government's claims against Eastern Indemnity, pursuant to 31 U.S.C. § 3713.[2] The federal government's claims against Eastern Indemnity arose principally from performance and payment bonds issued by Eastern Indemnity in which the United States and its agencies and instrumentalities were obligees.[3]

Accordingly, the priority demanded by the federal government was primarily for claims in which the government was a policyholder, beneficiary or insured of Eastern Indemnity, a position functionally identical to all other, albeit private sector, claimants. The government, however, demanded dollar-for-dollar payment of its claims under Section 3713, instead of the pro-rata payment which it would receive under the Maryland Insurance Code. Payment of the government's claims as demanded would consume all of the receivership assets, leaving nothing to pay either the

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[2] Section 3713, originally enacted in 1797, carries with it the threat of personal liability against the Special Deputy State Insurance Commissioner should he fail to comply with the priority demanded by the government.

[3] Although the Respondent did not attach a dollar value to the government's claims, the Special Deputy State Insurance Commissioner estimated these claims to be in excess of $3.9 million.

$18 million in policyholder claims not covered by guaranty funds, or the subrogation claims of the guaranty funds.

Respondents were informed that compliance with the government's requested priority would entirely consume Eastern Indemnity's liquid assets, result in wholesale denial of valid policyholder claims, and render nugatory the Maryland Insurance Code provisions regulating insurance company insolvencies and payment of claims. Respondents nevertheless continued to demand dollar-for-dollar payment under Section 3713, rejecting the requirement of the Maryland Insurance Code priority payment system that the federal government's policy beneficiary claims be paid on a pro-rata basis.

Accordingly, the Special Deputy State Insurance Commissioner filed suit pursuant to 28 U.S.C. §§ 1331(a) and 2201-2202, seeking a declaration that the payment of policyholder claims against Eastern Indemnity is governed by the provisions of the Maryland Insurance Code, as opposed to the federal priority statute. He took this position because the primary purpose of the McCarran-Ferguson Act, 15 U.S.C. § 1011 *et seq.*, is ensuring that the regulation of the business of insurance remain a matter of state - not federal - law and that state regulation be accomplished without federal interference.[4]

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[4] The relevant portion of the statute reads as follows:

> No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance, or which imposes a fee or tax upon such

D. The Decisions Of The Courts Below

Noting that the facts were "basically undisputed," App. at 7a, the United States District Court for the District of Maryland decided the case on motions by each party for summary judgment. Although the trial court agreed that, if granted, the priority asserted by Respondents would invalidate, impair or supersede the applicable provisions of the Maryland Insurance Code, App. at 12a, the court rejected the argument that the Maryland provisions regulating payment of claims against insolvent insurance companies constitute the "business of insurance," a prerequisite for application of the McCarran-Ferguson Act preemption.[5] As support for its conclusion, the trial court relied upon the

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business. . . .

15 U.S.C § 1012(b).

[5] In support of his motion, the Special Deputy State Insurance Commissioner cited two district court cases to the contrary. Each directly holds that state insurance code provisions governing the liquidation of insolvent insurance companies constitute the regulation of the business of insurance under the McCarran-Ferguson Act. *Washburn v. Cochran*, 643 F. Supp. 554 (S.D. N.Y. 1986); *Idaho ex rel. Soward v. Internal Revenue Service*, 662 F. Supp. 60 (D. Idaho 1987), *app. pending*, No. 87-4057 (9th Cir.).

The district court found these precedents unpersuasive because they did not discuss and follow three decisions of this Court construing the McCarran-Ferguson Act in the context of that statute's narrow exemption of the business of insurance from the federal antitrust laws. *Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119 (1982); *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205 (1979); and *Securities and Exchange Commission v. National Securities, Inc.*, 393 U.S. 453 (1969).

test articulated by this Court in *Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119 (1982) for determining whether insurance company activity constitutes the business of insurance and is, therefore, exempt from the federal antitrust laws by virtue of the McCarran-Ferguson Act's narrowly construed antitrust exemption. App. at 14a.

Accordingly, the district court concluded that the McCarran-Ferguson Act was inapplicable and that the federal priority statute governed in lieu of the Maryland Insurance Code. Summary judgment was, therefore, entered in favor of Respondents.

The Special Deputy State Insurance Commissioner appealed to the United States Court of Appeals for the Fourth Circuit. That court declined to address the arguments of the Special Deputy State Insurance Commissioner and, in a brief *per curiam* opinion, merely adopted the opinion of the district court as its own. *See* App. at 5a.

REASONS FOR GRANTING THE WRIT

The decision below that state regulation of the winding up of an insolvent insurance company's affairs and the payment of policyholder claims made against it do not constitute regulation of the business of insurance for purposes of the McCarran-Ferguson Act raises several important unresolved questions.

I

The McCarran-Ferguson Act, the Primary Purpose of which is to Ensure Continued State Regulation of the Business of Insurance, Mandates that the Payment of Policyholder Claims Against an Insolvent Insurance Company be Governed by the Maryland Insurance Code

This case presents this Court with the significant and urgent task of deciding a conflict between two federal statutes which cannot coexist without action by this Court to clarify their meaning. Resolving that conflict will also permit harmonizing of two separate, superficially inconsistent lines of Supreme Court cases that have given ambiguous guidance to lower federal courts.

At stake is the stability of the multi-billion dollar insurance industry which, as the result of the McCarran-Ferguson Act, relies solely on state regulation. The immediate legal issue is whether payment of policyholder claims against an insolvent insurance company will be governed by the primary purpose of the McCarran-Ferguson Act, which is to ensure continued state regulation of the business of insurance, or instead by 31 U.S.C. § 3713, the sole purpose of which is to generate income for the federal government. By resolving this pressing question, this Court will also, for the first time in thirty years, be in a position to decide whether provisions of a state insurance code, designed to fulfill the paramount goal of insurance regulation, constitute the business of insurance for purposes of the McCarran-Ferguson Act. Numerous other states have similar insurance code provisions, the interpretation of which will be significantly affected by the outcome of this case.

As evidenced by the decision below, there exists a serious and unresolved conflict between two important federal statutes, each of which was adopted to further important, yet fundamentally different, national policies. On the one hand there is the McCarran-Ferguson Act, which itself is intended to accomplish two distinct goals: first, to ensure that the states will regulate the business of insurance, and second, to afford a limited antitrust exemption from federal antitrust laws to insurance companies. *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205, 218 n.18 (1979). On the other hand there is 31 U.S.C. § 3713, one of the first laws enacted by the republic, which was designed to raise revenue for the federal government. The holding below that Section 3713 governs instead of the McCarran-Ferguson Act results in the partial invalidation of the McCarran-Ferguson Act and the policies served by its primary goal. This Court has never before addressed this statutory conflict and, until it does, the ability of state insurance regulators to discharge their responsibilities to policyholders is in serious jeopardy.

There also exists serious uncertainty with respect to the definition of the term "business of insurance," as it is used in the McCarran-Ferguson Act. This uncertainty is caused by the decisions of this Court, which have not directly construed the primary purpose of the McCarran-Ferguson Act in thirty years. Instead, this Court's recent decisions construing the Act have been confined to the altogether different, secondary antitrust exemption purpose, without clarifying the limited nature of these decisions.[6] Conse-

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[6] As discussed more fully, *infra*, and as recognized by Justice

quently, lower federal courts are rendering decisions which call into question the continued validity of this Court's early decisions interpreting the McCarran-Ferguson Act and, therefore, lower federal courts are in need of prompt guidance from this Court in this important area.

It is well established that the primary purpose of the McCarran-Ferguson Act is to ensure continued state regulation of the business of insurance. *Royal Drug*, 440 U.S. at 218 n.18. Congress' goal in passing the statute was "*broadly* to give support to the existing and future state systems for regulating and taxing the business of insurance." *Prudential Ins. Co. v. Benjamin*, 328 U.S. 408, 429 (1946) (emphasis supplied). The narrow antitrust exemption of the McCarran-Ferguson Act, from which the three-part *Pireno* test is derived, constitutes only a secondary purpose of the Act. *Royal Drug*, 440 U.S. at 218 n.18. Significantly, exemptions from the antitrust laws are to be narrowly construed. *Id.* at 231.

It is similarly well established that one of the broad goals of state insurance regulation is ensuring the solvency of insurance companies. *Securities and Exchange Commission v. Variable Annuity Life Ins. Co.*,

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Brennan in his dissenting opinion in *Royal Drug*, 440 U.S. at 233-38, this Court's early cases construing the McCarran-Ferguson Act concerned the statute's primary purpose of broadly ensuring that the states continued to regulate the business of insurance. *See, e.g., Federal Trade Commission v. National Casualty Co.*, 357 U.S. 560 (1958); *Prudential Ins. Co. v. Benjamin*, 328 U.S. 408 (1946) and *Robertson v. California*, 328 U.S. 440 (1946). As will be demonstrated, these early McCarran-Ferguson Act cases are inconsistent with this Court's more recent pronouncements in the context of the Act's narrow antitrust exemption.

359 U.S. 65, 77 (1959) (Brennan, J., concurring). This Court has explicitly recognized that whether an insurance company will meet its contractual obligation and pay a covered claim when due is the "only concern" of the carrier's policyholder. *Pireno*, 458 U.S. at 132. Stated differently, the "reliability, interpretation and enforcement" of an insurance policy, i.e., whether an insurer will pay a covered claim, is at the heart of the relationship between the insurer and insured. *National Securities, Inc.*, 393 U.S. at 460.[7] Accordingly, the *Pireno* test, articulated in the antitrust context of the McCarran-Ferguson Act, is of dubious value in resolving a case such as this, which arises under the broad primary regulatory purpose section of the statute.

The Maryland Insurance Code provisions at issue directly regulate whether the covered claims of policyholders against insolvent insurers will be paid.

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[7] In *Royal Drug*, 440 U.S. at 223, this Court acknowledged that the Congress which enacted the McCarran-Ferguson Act was aware that the very purpose of insurance regulation was concern over insurer solvency. *See also* 91 Cong. Rec. 1481 (1945) (remarks of Sen. Ferguson); 90 Cong. Rec. 6564-65 (1944) (remarks of Rep. Vorys); and 90 Cong. Rec. 6526 (1944) (remarks of Mr. Hancock that "the solvency of the insurer is of prime importance. . ."). Additionally, learned insurance treatises support the proposition that unless a policyholder's claim is actually paid upon the occurrence of an insured risk, no risk has in fact been transferred. *See infra* at 22 n.13.

In this regard it is significant to recall that in *Royal Drug*, 440 U.S. at 210-12, this Court noted that because the phrase "business of insurance" is not defined in the McCarran-Ferguson Act, resort both to the legislative history of the statute and authoritative insurance treatises is necessary to discern the meaning of the phrase.

Through the statutory provisions cited, *supra*, the Maryland legislature has provided that covered policyholder claims against an insolvent insurer will be paid pro-rata in a certain priority, so as to fulfill the payment expectations of the maximum number of policyholders to as great an extent as possible.

Relying on *Pireno* and *Royal Drug*, the Fourth Circuit has nevertheless held that the Maryland Insurance Code provisions designed to fulfill the paramount goal of insurance regulation, protection of the policyholder, are preempted by a federal statute, which was designed to generate income for the United States and was passed at a time when modern insurance companies and regulatory programs did not exist. The effect of this ruling will result in the denial of millions of dollars in policyholder claims, and in this case wholly consume the assets available to the Special Deputy State Insurance Commissioner to administer the receivership in accordance with the goal of the Maryland Insurance Code: paying similarly situated claimants on a pro-rata basis. Accordingly, this Court should resolve the important questions presented concerning the interpretation of the McCarran-Ferguson Act's state regulatory provision and clarify the present uncertainty as to continued state regulation of insolvent insurance companies.

Simply put, *Pireno* and *Royal Drug* are inapplicable to the matters at bar because those cases involved efforts by insurance companies to use the McCarran-Ferguson Act as a shield from suits charging them with antitrust violations. As this Court pointed out in *Royal Drug*, the primary purpose of the McCarran-Ferguson Act was to "preserve state regulation of the activities of insurance companies." *Royal Drug*,

440 U.S. at 218 n.18. That purpose was manifestly not involved in *Royal Drug*, which concerned the McCarran-Ferguson Act's secondary purpose: affording insurance companies limited exemption from the federal antitrust laws. *Id.* at 207-10, 215, 217-18. Similarly, *Pireno* did not involve the primary regulatory purpose of the McCarran-Ferguson Act, but instead involved the Act's secondary antitrust function. *Pireno*, 458 U.S. at 126. The fundamental distinction between the Act's two purposes demonstrates the impropriety of invalidating a state statute regulating the payment of insurance claims, an issue arising under the statute's primary regulatory purpose, by employing the logic of two antitrust cases which arose under the Act's narrowly construed secondary purpose.

More importantly, application of the three-part *Pireno* test outside the context of the McCarran-Ferguson Act's secondary purpose antitrust exemption produces results directly conflicting with this Court's interpretations of the McCarran-Ferguson Act's primary regulatory purpose provision.[8] In *Robertson v. California*, 328 U.S. 440 (1946), decided the year after passage of the McCarran-Ferguson Act, this Court ruled that the California Insurance Code provisions requiring licensing of insurance companies and their brokers would constitute the regulation of the business of insurance under the McCarran-Ferguson Act. *Id.* at 462. That case involved the primary regulatory function of the McCarran-Ferguson Act, not its sec-

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[8] Under the three-part *Pireno* test, a practice constitutes the business of insurance if it: (a) involves the transfer or spreading of risk; (b) involves the relationship between insurer and insured; and (c) if all parties to the practice are within the insurance industry. *Pireno*, 458 U.S. at 127-29; App. at 3a.

ondary antitrust exemption purpose. The result reached upon application of the *Pireno* test to the facts of *Robertson*, however, directly conflicts with this Court's holding in *Robertson* because the practice under scrutiny in *Robertson* would not pass the first and most important prong of the three-part *Pireno* test: the requirement that insurance companies be licensed has nothing whatsoever to do with the underwriting or transfer of policyholder risk.

Similarly, in *Federal Trade Commission v. National Casualty Co.*, 357 U.S. 560 (1958), this Court held that state insurance code provisions governing insurance company advertisements constituted the regulation of the business of insurance under the McCarran-Ferguson Act, and that the Federal Trade Commission was, therefore, precluded from regulating this activity. Once again, the result reached if the *Pireno* test were to be applied to the facts of *National Casualty Co.* directly conflicts with this Court's ruling in *National Casualty Co.* The regulation of insurance company advertisement does not pass *any* prong of the *Pireno* test: it does not involve the underwriting or transfer of policyholder risk; it does not involve insurer-insured relationships; and it clearly encompasses third parties outside of the insurance industry.

This Court's decisions have produced a graphic conflict between the holdings in the primary regulatory purpose context in *Robertson* and *National Casualty Co.* and the decisions following the *Pireno* test. Under the *Pireno* analysis, *Robertson* and *National Casualty Co.* would have to be decided differently. This should not be so, however, because exemptions to the antitrust laws are to be narrowly construed, *Royal Drug*, 440 U.S. at 218 n.18, while the McCarran-Ferguson

Act's primary purpose of preserving state regulation of the business of insurance is to be broadly construed. *Benjamin*, 328 U.S. at 429. Thus, the rigorous *Pireno* test quite properly applies in cases arising under the McCarran-Ferguson Act's secondary purpose, exempting certain insurance company conduct from the federal antitrust laws, but not in cases such as the instant one which arise under the broadly construed primary purpose of the statute, ensuring continued state regulation of the business of insurance. Because this Court has not interpreted the Act's broadly construed state regulatory provision since long before it announced the *Pireno* test, clarification of the jurisprudence concerning the regulatory provisions of the McCarran-Ferguson Act is in order.[9]

The urgent need for clarification is illustrated by the conflict between the decision below and two recent United States District Court opinions. In *Idaho ex rel. Soward*, 662 F. Supp. 60, the court was faced with the identical issue presented in this case, i.e., whether the government has priority under Section 3713 over payments from the assets of an insurance receivership. In *Washburn*, 643 F. Supp. 554, the court was asked to decide whether provisions of a

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[9] In *Pilot Life Ins. Co. v. Dedeaux*, 107 S.Ct. 1549 (1987); *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985); and *Arizona Governing Committee v. Norris*, 463 U.S. 1073 (1983), this Court utilized the *Pireno* definition of the "business of insurance" as a guide in interpreting federal statutes other than the McCarran-Ferguson Act. Accordingly, those cases are inapplicable to the case at bar which directly involves construction of the primary state regulatory provision of the McCarran-Ferguson Act.

state insurance code dealing with the liquidation of an insolvent insurance company constituted the business of insurance for purposes of the McCarran-Ferguson Act. Unlike the courts below, these courts recognized that the purpose of the respective state insurance codes was to provide policyholders and the public with "cradle to grave" regulation of the insurance business, which includes regulation of the liquidation of an insolvent insurance company. Each court, therefore, concluded that the state liquidation provisions did constitute the business of insurance, and, in *Idaho ex rel. Soward*, that the priority sought by the United States Government under Section 3713 was precluded by the McCarran-Ferguson Act.

The conflict between this Court's holdings in *Robertson* and *National Casualty Co.* and the results reached in those cases when the *Pireno* test is applied, as well as the conflict between the decision below and the two district court decisions reaching the opposite result, demonstrates the need for this Court to clarify the status of the McCarran-Ferguson Act in the primary purpose state regulatory context.

II

The Issues Raised in This Petition are of Far-Reaching National Significance

The questions at issue are far reaching and of national significance. Most state insurance codes have provisions similar to that of Maryland, and give priority to payment of policyholder claims from the assets of an insolvent carrier ahead of other claims.[10] More-

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[10] *See, e.g.*, Colo. Rev. Stat. § 10-3-507 (1987 Repl. Vol); Conn.

over, the number of pending insurance company receiverships is large and growing. According to figures compiled by the National Association of Insurance Commissioners ("NAIC"), more than 100 insurance company receiverships were pending in 27 states as of 1986. *See* American Bar Association, *Reference Handbook on Insurance Company Insolvency* 621-41 (1986). The reality of insurance liquidations is that available assets are inevitably insufficient to pay all policyholder claims in full. *See, e.g.*, Traylor, "The Liquidation Process," in *Law and Practice of Insurance Company Insolvency* 62, 82, 86-87 (1986). In response to this reality, the various state insurance codes give priority of payment to policyholder claims so as to fulfill policyholder payment expectations to the maximum extent possible. The result reached by applying the test arising under the McCarran-Ferguson Act's narrowly drawn antitrust exemption frustrates this state regulatory program by permitting the federal government to step in front of policyholders to repay itself in full, and, as in this case, consume all of the assets which otherwise would have been available to pay policyholder claims.

Only action by this Court will eliminate this significant, recurring and growing problem. The legal issues and underlying policy issues are clear. Awaiting further, conflicting lower court decisions will unnecessarily create confusion in the insurance industry,

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Gen. Stat. § 38-462 (1982); Fla. Stat. § 631.271 (1987 Repl. Vol); Idaho Code § 41-3342 (1987 Cum. Supp.); Ill. Rev. Stat. ch. 73 § 205 (1988 Cum. Supp.); Mass. Gen. Laws Ann. ch. 175, § 180F (1988 Cum. Supp.); Ohio Rev. Code Ann. § 3903.42 (1987 Supp.); Pa. Stat. tit. 40, § 221.44; Tex. Ins. Code Ann. § 21.28B; Wis. Stat. §§ 645.68 (1)-(11) (1987 Cum. Supp.).

particularly in connection with the handling of insurance company insolvencies.

III

The Legislative History of the McCarran-Ferguson Act and Learned Insurance Treatises Demonstrate that the Relevant Maryland Insurance Code Provisions Regulate the Business of Insurance

Finally, the legislative history of the McCarran-Ferguson Act and learned insurance treatises demonstrate that the statutes in question manifestly regulate the business of insurance. This is true even assuming, *arguendo*, that the *Pireno* test is relevant in ascertaining whether the Maryland Insurance Code provisions dealing with the liquidation of insolvent insurance companies regulate the business of insurance.

In this regard, it is significant to note that in discharging his statutory obligation of paying covered claims made against Eastern Indemnity, the Special Deputy State Insurance Commissioner must, as a preliminary matter, determine whether a purported policyholder claim is, in fact, covered by the policyholder's Eastern Indemnity policy. In doing so, he acts as the adjustor for the insurance company. Md. Ann. Code art. 48A, § 132. In *Pireno*, 458 U.S. 134 n.8, this Court explicitly recognized that claims adjustment does, indeed, constitute the business of insurance. Accordingly, even under *Pireno*, it is clear that the regulations at issue here, which empower the Special Deputy State Insurance Commissioner to ad-

just claims against Eastern Indemnity, regulate the business of insurance.[11]

With regard to the first element of the *Pireno* test, whether the statutes in question relate to the underwriting and transfer of policyholder risk, it is important to recall that the phrase "business of insurance" is not defined in the McCarran-Ferguson Act. Accordingly, in *Royal Drug*, 440 U.S. at 210-12, this Court instructed that resort to both the legislative history of the Act and authoritative treatises on insurance are necessary to discern the meaning of this phrase. Significant portions of the legislative history of the McCarran-Ferguson Act demonstrate clear Congressional awareness that insurance is a unique commodity, because it involves the payment of a premium for protection which might not be needed for years to come. If insurance is to fulfill the promise of protection purchased by the policyholder, the company selling the insurance must be able to back up its promise with actual payment at the time of loss.[12]

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[11] The dissenting opinion in *Royal Drug*, 440 U.S. at 236-237, recognized that what the states considered to be regulated as insurance at the time the McCarran-Ferguson Act was passed is relevant in defining the contours of "the business of insurance." Moreover, the dissent also recognized the importance of this Court's earlier decisions construing the Act's primary purpose state regulatory provision. *Royal Drug*, 440 U.S. at 235-237.

[12] *See* remarks of Senator Ferguson, one of the authors of the McCarran-Ferguson Act, as to the purposes of the statute:

> The sale of insurance is not the same as the sale of an article in a store. When one buys an article in a store, he brings it home with him. In the case of insurance, he buys a promise to pay upon the hap-

The same concept, that the essence of insurance is the fulfillment of the transfer of risk by the actual payment of benefits upon the occurrence of a loss, is well supported by learned commentators on the insurance industry.[13]

The regulatory procedures of the Maryland Insurance Code governing insurance company liquidation, like those in virtually every other state, are aimed at fulfilling the promise of insurance by seeing to it that claims of policyholders, insureds and beneficiaries receive priority payment in the event of insurer insolvency. Indeed, the insolvency provisions of the Maryland Insurance Code are but a single part of a regulatory whole which applies to all aspects of insurance from cradle to grave. The holding below arose from the courts' failure to appreciate that this Court's opinions in *Royal Drug* and *Pireno* did not address direct efforts by state insurance regulators to enforce provisions of their insurance codes for the protection of the public. Rather, *Royal Drug* and *Pireno* involved efforts by insurance companies to invoke the Mc-

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> pening of a certain event, and that event may be the burning of his home. If the company is not sound and solvent at the time the house burns, or at the time the claim is made, there is not insurance at all. That is what we have tried to avoid.

91 Cong. Rec. 1481 (1945). *See also* 90 Cong. Rec. 6564-65 (1944) (remarks of Rep. Vorys); 90 Cong. Rec. 6526 (1944) (remarks of Rep. Hancock).

[13] *See* 2 G. Richards, *The Law of Insurance*, § 207 (W. Freedman, 5th ed. 1952); *Couch on Insurance* § 1:3 (2d rev. ed. 1984); William and Heins, *Risk Management and Insurance* 279 (5th ed. 1985); Athearn and Pritchett, *Risk and Insurance* (5th ed. 1984).

Carran-Ferguson Act as protection against enforcement of federal antitrust laws and this Court made clear in *Royal Drug* that the antitrust exemption at issue was to be narrowly construed. Only action by this Court can clear up the confusion surrounding interpretation of the McCarran-Ferguson Act's primary regulatory context.

Similarly, the Maryland Insurance Code liquidation provisions pertain to the relationship between the insurer and the insured and, therefore, constitute the regulation of the business of insurance. In *National Securities, Inc.*, 393 U.S. at 460, this Court ruled that the very heart of the business of insurance was the "relationship between insurer and insured, the type of policy which could be issued, its reliability, interpretation and enforcement—these were the core of the business of insurance." The Maryland Insurance Code's liquidation provisions are designed to assure the reliability and enforcement of insurance policies, even after insolvency of the company which issued them, by mandating priority payment to the policyholders.[14]

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[14] Finally, the Maryland Insurance Code provisions at issue involve only insurance industry parties. The Special Deputy State Insurance Commissioner, as receiver for Eastern Indemnity, serves as the adjustor of claims against Eastern Indemnity. Md. Ann. Code art. 48A, § 132. In this capacity, he determines whether a purported policyholder claim is, in fact, covered by the particular Eastern Indemnity policy in question. Only if the Special Deputy State Insurance Commissioner resolves that question in favor of the policyholder and determines that the claim is covered by the Eastern Indemnity policy does the policyholder even have a right to claim against the assets of the receivership in the priority established by the Maryland Insurance Code.

Until this Court acts to clear up the confusion surrounding state efforts to protect policyholders in the event of insurance company insolvency, insurance regulatory efforts to protect policyholders in Maryland and virtually every other state will be threatened. Given the large number of pending insurance company liquidations, and the certainty of more in the future, the issues presented in this case are of widespread importance and merit prompt resolution by this Court.

CONCLUSION

For all of the foregoing reasons, the petition for certiorari should be granted. If Petitioner is correct and the Maryland statutes regulate the business of insurance, then the case should be remanded to the district court for entry of summary judgment in Petitioner's favor so that Eastern Indemnity's policyholders may all be paid on a pro-rata basis, rather than permitting the federal government to seize all of Eastern Indemnity's available assets under a statute designed to assist the government in its collection efforts.

Respectfully submitted,

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APPENDIX

UNITED STATES COURT OF APPEALS
FOR THE FOURTH CIRCUIT

No. 87-1703

JAMES A. GORDON, Special Deputy State Insurance Commission of Maryland and Receiver, Eastern Indemnity Company of Maryland in Receivership

Plaintiff-Appellant

versus

UNITED STATES DEPARTMENT OF THE TREASURY; W.E. DOUGLAS, Commissioner, United States Department of the Treasury, Fiscal Service;

Defendants-Appellees

NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS; ILLINOIS INSURANCE GUARANTY FUND; PROPERTY AND CASUALTY INSURANCE GUARANTY CORPORATION; WISCONSIN INSURANCE SECURITY FUND; TEXAS PROPERTY AND CASUALTY INSURANCE GUARANTEE ASSOCIATION; JAMES T. ODIORNE, in his capacity as Texas Ancillary Receiver for Eastern Indemnity Company

Amici Curiae

Appeal from United States District Court for the District of Maryland, at Baltimore. Walter E. Black, Jr., District Judge. (CA-86-3354-B)

Argued: May 4, 1988 **Decided: May 20, 1988**

Before WINTER, Chief Judge, SPROUSE, Circuit Judge, and KAUFMAN, Senior United States District Judge for the District of Maryland, sitting by designation.

Paul W. Grimm (David D. Gilliss, JORDAN, COYNE, SAVITS & LOPATA on brief) for Appellant. (Carole J. Olson, NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS on brief) for Amicus Curiae National Association of Insurance Commissioners (Thomas W. Jenkins, Hugh C. Griffin, Mark R. Goodman, LORD, BISSELL & BROOK on brief) for Amici Curiae The Illinois Insurance Guaranty Fund, The Property and Casualty Insurance Guaranty Corporation, The Texas Property and Casualty Insurance Guarantee Association, The Wisconsin Insurance Security Fund, and James T. Odiorne in his capacity as Texas Ancillary Receiver for Eastern Indemnity Company of Maryland. Sandra P. Spooner, Deputy Director (Richard K. Willard, Assistant Attorney General; J. Christopher Kohn, Director, Civil Division, DEPARTMENT OF JUSTICE on brief) for Appellees.

PER CURIAM:

James A. Gordon appeals the district court's judgment that the United States, in its capacity as a policyholder, is entitled to priority of payment in the liquidation of an insolvent insurance company, Eastern Indemnity Insurance Company (EICOM). *See* Gordon v. United States Department of the Treasury, 668 F. Supp. 483 (D. Md. 1987). As Special Deputy State Insurance Commissioner of Maryland and Receiver for EICOM, Gordon contends that Maryland state law governing the priority of payment of such claims, Md. Ins. Code Ann. art. 48A, §§ 158, 158A (1986), constitutes state regulation of the "business of insurance" within the meaning of the McCarran-Ferguson Act of 1945, 59 Stat. 33, as amended, 15 U.S.C. §§ 1011-15 (1982), and should therefore preempt, by operation of 15 U.S.C. § 1012(b), the government's claim to priority under 31 U.S.C. § 3713 (1982).

The district court concluded that the liquidation of an insolvent insurance company and the determination of the priority of payment of claims against the insolvent do not constitute the "business of insurance" within the meaning of the McCarran-Ferguson Act. It therefore held that the government's claim under the federal priority statute could prevail over a contrary state regulation of the business of insurance companies without contravening 15 U.S.C. § 1012(b). Its decision was properly guided by the Supreme Court decisions in Group Life & Health Insurance Co. v. Royal Drug Co., 440 U.S. 205 (1979), and Union Labor Life Insurance Co. v. Pireno, 458 U.S. 119 (1982), construing the term "business of insurance."[1]

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[1] In *Pireno*, the Supreme Court set forth three factors relevant to whether a practice is part of the "business of insurance": whether the practice has the effect of transferring or spreading a policyholder's risk; whether the practice is an integral part of the policy relationship between the insurer and the insured; and whether the practice is limited to entities within the insurance industry. *Pireno*, 458 U.S. at 129.

We reject Gordon's contention that the district court erred in relying on these opinions outside of the antitrust context. The Supreme Court's discussions of the definition of "business of insurance" in *Pireno* and *Royal Drug* are not, expressly or by logical implication, limited to the antitrust context. *See, e.g.,* Pilot Life Insurance Company v. Dedeaux, ___ U.S. ___, 107 S. Ct. 1549, 1553-54, 95 L.Ed.2d 39, 48-50 (1987) (whether Mississippi law of bad faith is state law regulating insurance); Metropolitan Life Insurance Co. v. Massachusetts, 471 U.S. 724, 743 (1985) (applying similar preemption language to state mandated-benefits law).

We agree with the district court's application of *Pireno*'s first factor: for the reasons given by the district court, the risk of insurer insolvency is certainly qualitatively distinct from the risk the policyholder seeks to transfer in an insurance contract. *See* 668 F. Supp. at 489-90. In some contexts such as an insurer's liquidation, *Pireno*'s first factor (whether a practice has the effect of transferring or spreading the policyholder's risk) may justifiably play a preeminent role in the § 1012(b) analysis. However, it is not necessary to review the correctness of the district court's statement that the first of the *Pireno* considerations should be a categorically "indispensable" requirement for a finding that a practice constitutes the "business of insurance." *See* 668 F. Supp. at 490-91. The district court's characterization of this factor as indispensable was not necessary to reach the result it did; the court did discuss the other two factors elaborated in *Pireno,* correctly concluding that they also weighed in favor of its holding that Maryland's regulation of the liquidation process of insurance companies, while perhaps the regulation of the business of insurers, was not the regulation of the "business of insurance" within the meaning of McCarran-Ferguson. *Id.* at 491; *see Royal Drug,* 440 U.S. at 211.[2]

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[2] *But see* Idaho ex rel. Soward v. United States, 662 F. Supp. 60

We decline to decide whether the first factor of *Pireno* may in some instances or in all cases be an indispensable requirement for a finding that a certain practice constitutes the "business of insurance." In all other respects, we are satisfied with what the district court said, and we adopt as our opinion that of the district court, 668 F. Supp. 483 (D. Md. 1987).

AFFIRMED.

(D. Idaho) (failing to discuss *Pireno* or *Royal Drug*), *appeal pending*, No. 87-4057 (9 Cir. 1987); Washburn v. Corcoran, 643 F. Supp. 554 (S.D.N.Y. 1986) (same).

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MARYLAND

JAMES A. GORDON, SPECIAL DEPUTY STATE INSURANCE COMMISSIONER OF MARYLAND AND RECEIVER, EASTERN INDEMNITY COMPANY OF MARYLAND IN RECEIVERSHIP	*	CIVIL NO. B-86-3354
v.	*	
UNITED STATES DEPARTMENT OF THE TREASURY, W. E. DOUGLAS, COMMISSIONER, UNITED STATES DEPARTMENT OF THE TREASURY, FISCAL SERVICE	*	

Filed: August 31, 1987

Paul W. Grimm, Esq., and David D. Gilliss, Esq., of Baltimore, Maryland, for Plaintiff.

Robert N. McDonald, Esq., Assistant United States Attorney, of Baltimore, Maryland, and J. Christopher Kohn, Esq., and Sandra P. Spooner, Esq., of Washington, D.C. for Defendants.

BLACK, DISTRICT JUDGE.

This case presents for resolution the always problematic situation that arises when a company lapses into insolvency and there is simply not enough money to satisfy each of the outstretched hands. The complexity of this insolvency is compounded by the existence of private as well as gov-

ernment creditors and a conflict in state and federal priority statutes. Whether the general rule of governmental priority shall apply to the facts of this particular case hinges exclusively upon the issue of whether the process of liquidating an insolvent insurance company and paying claimants constitutes the "business of insurance."

The facts underlying this case are basically undisputed. The Eastern Indemnity Insurance Company (hereinafter "EICOM") was licensed by the State of Maryland to do business in 1980. Its insurance business rapidly expanded to include more than thirty states throughout the United States. Primarily, its business involved the underwriting of surety bonds for contractors.

In 1984, the State Insurance Commissioner launched an investigation into the financial affairs of EICOM, and EICOM was thereafter placed into voluntary rehabilitation as provided by the Maryland Insurance Code. Md. Ann. Code art. 48A, § 132 (1957). In 1985, the Circuit Court for Montgomery County, Maryland, ordered the liquidation of EICOM, and the company was then declared to be insolvent. The plaintiff, James Gordon, acting in his capacity as Special Deputy State Insurance Commissioner of Maryland, was appointed Receiver for EICOM. Gordon was to handle the day-to-day activities involved in the liquidation of this failed insurance business.

Among the duties of Gordon as Receiver was the settlement and supervision of the claims of the policyholders of EICOM. In accordance with the Maryland Insurance Code, a date was established by which time the claimants of EICOM were to file their claims or be forever barred. After the passage of the deadline, Gordon determined that the claims filed exceeded 75 million dollars. Though the amount of their assets is not easily calculable, it is, in any event, far less than the amount necessary to satisfy the claimants in full. Of the more than 75 million dollars in claims filed against EICOM, approximately 61 million dol-

lars are made up of claims submitted by principals, obligees, material suppliers and subcontractors in connection with surety bonds issued by EICOM. Many of the projects for which EICOM issued performance and payment bonds were Miller Act construction projects. Thus, the United States Government is a claimant in addition to a number of private contractors.

By letter to Gordon from the defendant, W.E. Douglas, on behalf of the defendant, the U.S. Department of Treasury, the government asserted priority status to the assets of EICOM, which are subject to the control and administration of the plaintiff Gordon, in his official capacity as receiver for EICOM. The defendants also advised Gordon that, under the federal priority statute, he could be held personally liable for distributing assets in contravention of the statute. This litigation followed. On October 31, 1986, the plaintiff filed a complaint in federal court alleging that the action by the defendants in asserting a priority is illegal because it invalidates, impairs or supersedes provisions of the Maryland Insurance Code enacted for the purpose of regulating the business of insurance in contravention of the McCarran-Ferguson Act.[1] The plaintiff has sought a declaratory judgment that the defendants' assertion of a priority is illegal because it violates the McCarran-Ferguson Act and, further, that the defendants not take action to enforce the personal liability provision of the federal priority statute against Gordon.

This case involves the interplay of three statutes—two federal statutes and the Maryland Insurance code. Broad policy statements underlie each of their statutory schemes. The first, section 3713 of Title 31 of the United States

[1] The complaint also alleged that the claims of materialmen, suppliers and subcontractors pursuant to Miller Act construction projects "do not constitute debts owed to the United States"; however, the parties have resolved this issue without court intervention and, therefore, it need not be addressed here.

Code, establishes an absolute priority of government claims when an individual is insolvent and makes a voluntary assignment of property, has its property attached, or commits an act of bankruptcy.[2] It was Congress' purpose in enacting § 3713 to "protect the interest of the government in collecting money due to it where property of an insolvent debtor is involved." *W.T. Jones and Company v. Foodco Realty, Inc.*, 318 F.2d 881, 885 (4th Cir. 1963). Its provisions have been in effect since 1797, without any significant modifications. *U.S. v. Emory*, 314 U.S. 423, 428 (1942). Section 3713 is the government's authority for asserting a priority over the assets of EICOM. Moreover, subsection (b) expressly provides that Gordon, as representative of EICOM, is personally liable to the government for paying debts ahead of the governmental priority.[3]

The Maryland Insurance code establishes a comprehensive scheme for administering the liquidation of insolvent insurance companies. An important part of this Code is devoted to defining the types of claims which may be filed against an insurance company undergoing liquidation, and

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[2] Section 3713 provides in pertinent part that,

> (a)(1) A claim of the United States Government shall be paid first when—
>
> (A) a person indebted to the Government is insolvent and—
>
> (i) the debtor without enough property to pay all debts makes a voluntary assignment of property;
>
> (ii) property of the debtor, if absent, is attached; or
>
> (iii) an act of bankruptcy is committed . . . .

31 U.S.C. § 3713 (1983).

[3] "A representative of a person or an estate (except a trustee acting under Title 11) paying any part of a debt of the person or estate before paying a claim of the Government is liable to the extent of the payment for unpaid claims of the Government." 31 U.S.C. § 3713(b) (1983).

creating priorities for payment of these claims. For example, wages to officers and employees are paid first, administrative expenses are paid next and tax claims occupy the third priority. *See,* respectively, Md. Ann. Code art. 48A §§ 158 and 158A (1986). The category of priority claims relevant to this litigation is the fourth priority, namely, "[c]laims by policyholders, beneficiaries, and insureds . . . ." This category represents by far the largest amount of claims. The plaintiff contends that the claims of the government are on the same priority level as all "policyholders, beneficiaries, and insureds" and, therefore, fall within the fourth priority. The government disagrees and cites 31 U.S.C. § 3713. Indeed, if it were not for the special nature of this case, implicating the insurance industry, the outcome of this dispute would be clear: the claims of the government would take priority by virtue of § 3713.

The McCarran-Ferguson Act, 15 U.S.C. §§ 1011-1015, was enacted in 1945 due to congressional concern over federal regulation of insurance, traditionally a function of the states:

> Congress declares that the continued regulation and taxation by the several States of the business of insurance is in the public interest . . . .

15 U.S.C. § 1011 (1976); *see* S.Rep. No. 20, 79th Cong., 1st Sess., 2 (1945); H.R. Rep. No. 143, 79th Cong., 1st Sess., 2-3 (1945), U.S. Code Cong. Serv. 1945, p. 670 and the discussion of the Supreme Court's decision in *United States v. South-Eastern Underwriters Assn.,* 322 U.S. 533 (1944). Congress' second concern was the relationship between insurance ratemaking and the antitrust laws "[b]ecause of the widespread view that it is very difficult to underwrite risks in an informed and responsible way without intraindustry cooperation." *Group Life & Health Insurance v. Royal Drug Co.,* 440 U.S. 205, 221 (1979).

Consequently, a partial exemption from the antitrust laws was included in the McCarran-Ferguson Act. 15 U.S.C. § 1012(b)(1976). The critical passage in the McCarran-Ferguson Act is that,

> [n]o Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance, or which imposes a fee or tax upon such business, unless such Act specifically relates to the business of insurance . . . .

Id. Thus, the phrase "business of insurance" was born, and, so long as a state acts to regulate the "business of insurance," its legislation is free of the intervention of Congress, at least in the absence of a specific law enacted by Congress as to a given matter. *See* 19 *Appleman, Insurance Law and Practice* § 10323 (1982). Federal laws will not be construed to supersede state laws regulating the "business of insurance."

The sole question before this Court is whether the State of Maryland was acting to regulate the "business of insurance" when it established the statutory scheme regarding the liquidation of insolvent insurance companies and the priorities of claimants or policyholders for payment.[4] This narrow issue was fully briefed by the parties and the Court heard oral argument of counsel. Amicus curiae briefs were filed on behalf of the National Association of Insurance Commissioners and on behalf of the Illinois Insurance Guaranty Fund, the Property and Casualty Insurance Guaranty Corporation, and the Wisconsin Insurance Security Fund. The matter is formally before this Court on Cross-Motions for Summary Judgment. The Court notes at the outset that summary judgment is clearly appropriate where the Court is faced with a motion and

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[4] The question of whether other portions of the Maryland Insurance Code regulate the "business of insurance" is not before the Court and is not relevant to the Court's opinion and rulings in this case.

countermotion for summary judgment, wherein all parties admit to undisputed facts and are merely seeking a declaration of the law.

In broad terms, the legal question presented to the Court is whether the strictures of the McCarran-Ferguson Act afford protection to the state of Maryland's priority scheme for claimants of insolvent insurance companies. In order for the McCarran-Ferguson Act to apply, three elements must be met: (1) there must be a state statute intended to regulate or tax, (2) the "business of insurance" (3) which is invalidated, impaired, or superseded by an Act of Congress not expressly related to the business of insurance. Clearly, the Maryland Insurance Code was intended to regulate the insurance industry. Reorganization of insolvent insurance companies is a matter of state law and is handled through insolvency proceedings in state court. *Universal Marine Insurance Company, Ltd. v. Beacon Insurance Company,* 768 F.2d 84, 88 (4th Cir. 1985). Equally clear is that the federal priority statute "invalidates, impairs or supersedes" the priority scheme set forth in the state statute. Thus, the focus in this case is solely on the "business of insurance" issue.

Through several recent opinions, the Supreme Court has enunciated the considerations to use in deliberating on whether action by the state constitutes regulation of the "business of insurance" such that a federal law cannot operate to "invalidate, impair or supersede" its provisions. These Supreme Court cases effectively define and limit the antitrust exemption set out in the McCarran-Ferguson Act and are the controlling standards in determining what constitutes the "business of insurance." *See also, State of Maryland v. Blue Cross and Blue Shield,* 620 F. Supp. 907, 913 (D. Md. 1985).

Helpful to the Court's understanding of what constitutes the "business of insurance" is Justice Stewart's simple instruction in *Royal Drug,* 440 U.S. at 211, that the "busi-

ness of insurance companies."[5] In *Royal Drug,* a group of nonparticipating pharmacists brought an antitrust action against an insurance company claiming that they had entered into agreements with participating pharmacists to fix the retail price of drugs. Guided by congressional intent to establish only a limited exemption to the antitrust laws, the Court examined the allegedly illegal pharmacy agreements in light of the general concept of "insurance." The Court recognized two important features. First, that the primary element of insurance is the "spreading and underwriting of a policy-holder's risk." *Royal Drug,* 440 U.S. at 211. Thus, the concept of insurance involves some risk-taking on the part of the insurance company. The Court found that the pharmacy agreements with the insurance company in order to minimize its costs were unconnected to the basic contractual obligation the insurance company had made with its insureds to cover the cost of their prescription drugs.

The second common aspect of insurance is the existence of a contract between the insurer and the insured. *Id.* at 215. Citing the Court's earlier language in *Securities and Exchange Comm. v. National Securities, Inc.,* 393 U.S. 453, 460 (1969), Justice Stewart wrote,

> The relationship between insurer and insured, the type of policy which could be issued, its reliability, interpretation, and enforcement—these were the core of the 'business of insurance.' Undoubtedly, other activities of insurance companies relate so closely to their status as reliable insurers

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[5] *See also,* Justice Marshall's observation in *Securities and Exchange Comm. v. National Securities, Inc.,* 393 U.S. 458, 459 (1969) regarding the history of the McCarran-Ferguson Act: "The statute did not purport to make the States supreme in regulating all the activities of insurance *companies;* its language refers not to the persons or companies who are subject to state regulation, but to laws 'regulating the *business* of insurance.' "

> that they to [sic] must be placed in the same class. But whatever the exact scope of the statutory term, it is clear where the focus was—it was on the relationship between the insurance company and the policyholder.

Royal Drug, 440 U.S. at 215-16. The Court concluded that the pharmacy agreements were in no way related to the contractual relationship between the insureds and the insurance company. The fact that the pharmacy agreements were entered into in order to lower the cost of premiums or affect their status as a reliable insurer was reflective of many of the business decisions made by an insurance company. To interpret otherwise, the Court wrote, would be to extend the definition of "business of insurance" to almost every business decision of an insurance company. *Id.* at 217. The conclusion of the Supreme Court in *Royal Drug* was that the insurance company was not exempt from the antitrust laws because the pharmacy provider agreements were not regulation of the "business of insurance." After *Royal Drug*, it was clear that, though many aspects of insurance companies are regulated by state law, they do not necessarily constitute the "business of insurance." Provider agreements by insurance companies for the purchase of goods and services from third parties at a set price were not the "business of insurance."[6]

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[6] In *Royal Drug*, the Supreme Court discussed also the concept of "advance-payment medical-benefits plans" as distinguished from insurance. At the time of the enactment of the McCarran-Ferguson Act, corporations organized for the purpose of providing their members with medical services and hospitalization were not considered to be engaged in the insurance business at all, and thus were not subject to state insurance laws. *Id.* at 225-26. The Court went on to find that, even if these plans were considered to be insurance by various state legislatures, the incorporation of provider agreements to lower cost of prescription drugs would still not be considered the "business of insurance." The provider agreements were analogized to many statutes regulating diverse aspects of these advance payment plans (or of insurance plans)

The Supreme Court addressed the concept of "business of insurance," and narrowed its scope further in *Union Labor Life Insurance Co. v. Pireno*, 458 U.S. 119 (1982). The *Pireno* case involved an alleged conspiracy to eliminate price competition among chiropractors by means of a committee that advised an insurance company regarding the chiropractor's fees and treatments. The Supreme Court held that the insurance company's use of the committee to render opinions regarding the necessity of chiropractor treatment and the reasonableness of fees did not constitute the "business of insurance" to exempt such a relationship from the scope of the antitrust laws.

The Supreme Court finally enunciated in *Pireno* three criteria relevant in determining whether a particular practice is part of the "business of insurance": first, whether the practice has the effect of transferring or spreading a policyholder's risk; second, whether the practice is an integral part of the policy relationship between the insurer and the insured; and third, whether the practice is limited to entities within the insurance industry. *Id.* at 129.[7] The *Pireno* court stated further that none of the criteria were "determinative" in and of themselves, but that the practice must be examined in light of all three. *Id.* Though the challenged practice in *Pireno* in essence focused on the claims adjustment process, the Court declined to find that it constituted the "business of insurance."

The Court first stated that the practice was "logically and temporally unconnected to the transfer of risk" accomplished by the insurance policies. *Id.* at 130. Risk is

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including, "the composition of their boards of directors, when their books and records could be inspected, how they could invest their funds, *when they could liquidate* or merge . . . ." *Id.* at 230 n.38 (Emphasis added).

[7] The Supreme Court recently reaffirmed these three criteria in *Metropolitan Life Insurance Co. v. Massachusetts*, ___ U.S. ___, 105 S. Ct. 2380, 2391 (1985).

transferred at the time the contract of insurance is entered into between the insurer and insured and not later when, as in *Pireno,* the insurance company made the decision to pay a claim because it was thereafter determined to be "necessary" or "reasonable." Second, the Court determined that the insurer's use of the committee was not an integral part of the policy relationship between the insurer and insured because the insured has no interest in why his claim is paid but only in whether it is paid. *Id.* at 132. Finally, the Court observed that it was clear that the challenged practice was not confined to the insurance industry itself, but rather involved third parties "wholly outside" it. *Id.* Once again, the Supreme Court held that the challenged practice was not the "business of insurance" and the antitrust exemption of the McCarran-Ferguson Act did not apply.

Other cases decided by the Supreme Court and the lower courts are generally instructive in exemplifying what the "business of insurance" is and what it is not. For example, in *Royal Drug,* the Supreme Court noted that just because an agreement is necessary to provide insurance (such as provider agreements to minimize costs of service benefit insurance plans), it does not follow that it is also the "business of insurance." That an indemnity insurer must have a line of credit or other commercial arrangement with a bank in order to pay off monetary claims and to fulfill its obligations does not convert such an arrangement into the "business of insurance." *Royal Drug,* 440 U.S. at 214 n.9. Premium financing by an insurance company rather than a third party loan or finance company does not constitute the "business of insurance." *Perry v. Fidelity Union Life Insurance Co.,* 606 F.2d 468 (5th Cir. 1979) ("one can hardly claim that the extension of credit is an integral part of the insurance business." *Id.* at 470), *but see Lowe v. Aarco-American, Inc.,* 536 F.2d 1160 (7th Cir. 1976). Diversification of an insurance company into areas of commerce in order to lower the cost of goods or services to

its policyholders would not make such acquisitions the "business of insurance." *Royal Drug*, 440 U.S. at 215.

State laws deemed by the courts to regulate the business of insurance include, for example, those affecting the substantive content of insurance contracts, *Metropolitan Life Insurance Co. v. Massachusetts*, 105 S. Ct. 2380, 2391 (1985) (mandated minimum health benefits laws); the fixing of rates, *United States v. South-Eastern Underwriters Association*, 322 U.S. 533 (1944); the selling and advertising of policies, *FTC v. National Casualty Co.*, 357 U.S. 560 (1958); and the licensing of companies and their agents, *Robertson v. People of State of California*, 328 U.S. 440 (1946).

The pronouncements of the Supreme Court in *Pireno* and *Royal Drug* are absolutely controlling in this area of the law.[8] This Court has unequivocally adopted the so-called "*Pireno* test" used by the Supreme Court to define narrowly the "business of insurance." *Blue Cross and Blue Shield*, 620 F. Supp. 907. Having established a legal framework for the narrow issue presented here, the Court must now characterize the challenged statute in this case within these strictures.

Absolutely crucial to the finding that a statute regulates the "business of insurance" is the concept of risk transfer or spread, as necessitated by the quintessential definition of the term "insurance." Insurance is a "contract whereby, for a stipulated consideration, one party undertakes to compensate the other for loss on a specified subject by specified perils." *Black's Law Dictionary* 721 (5th ed. 1979). The consideration is payment proportionate to the

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[8] Thus, the authorities cited by plaintiff are not in the least persuasive as none analyze the concept of "business of insurance" in light of these Supreme Court cases. *Levy v. Lewis*, 635 F.2d 1960 (2d Cir. 1980); *State of Idaho v. Internal Revenue Service*, ___ F. Supp. ___ (D. Idaho 1987) (Civ. No. 85-1501); *Washburn v. Corcoran*, 643 F. Supp. 554 (S.D.N.Y. 1986).

risk involved. A finding that a challenged state statute involves the transfer or spread of risk will satisfy the first prong of the *Pireno* test.

This Court has held that more than a relationship to risk spreading must be shown to meet the *Pireno* criterion. *Blue Cross and Blue Shield,* 620 F. Supp. at 917 (D. Md. 1985). The party seeking the protection of the McCarran-Ferguson Act must show that the challenged priority scheme is "related positively to underwriting and rate-making." *Id.* That is, the practice of prioritizing claims such that all policyholders, including the United States, are treated similarly must "directly facilitate risk spreading and transfer through the provision of insurance." *Id.*

Plaintiff urges that the statutes specifically providing for liquidation of the insurance company and establishing the various priorities for claimants does reflect the concept of risk in the insurance industry. The risk that an insurance company will become insolvent, however, is not the kind of risk transfer emphasized in *Pireno* and *Royal Drug.* The fact that an insurance company may consider the possibility of insolvency as part of their overhead does not affect the essential obligation of the insurer to the insured as contained in the contract of insurance. The obligation of EICOM under its insurance policies to insure against risks of loss is wholly different from the procedure an insurance company must follow to pay claimants in case of insolvency. The policyholders are concerned with EICOM's recognition of its obligation to cover for their losses rather than the legal mechanisms involved in an insolvency proceeding and priority statute. *See, for example, Langdeau v. United States,* 363 S.W.2d 327, 331 (Tex. Cir. App. 1962) ("This is not a regulation of the insurance business; it is a priority established for a class of creditors of an insurance company").[9]

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[9] The *Langdeau* case too was decided pre-*Royal Drug* and *Pireno.*

Similarly, plaintiff contends that other insurance companies must bear the risk of loss of an insurance company in the form of higher premiums to the Maryland guaranty association (the "Property and Casualty Insurance Guaranty Corporation"), an entity created for the purpose of ensuring payment of claims and avoiding loss caused by the collapse of an insurance company. Md. Ann. Code art. 48A § 504 (1986). The guaranty association pays all valid "covered claims" and is then entitled to file a claim with the receivership for reimbursement. If there are insufficient assets to pay the guaranty association, it bears the risk of loss, rather than the insureds. *Id.* § 508. The funds of the guaranty association consist of premiums assessed against viable insurance companies operating in the state of Maryland. *Id.* § 508. The *Pireno* concept of risk transfer and spreading focuses on the policyholders and not the insurance premiums paid by third party insurance companies. Underwriting and ratemaking is far removed from the policy considerations underlying a state's enactment of a guaranty association. A previous legislative determination that losses would be covered by the guaranty association is "logically and temporally unconnected to the transfer of risk . . . ." *Pireno,* 458 U.S. at 130.

Finally, the Court rejects plaintiff's argument that there can be no transfer of risk until the policy is paid and because the priority statute affects payment of the policy when the company is insolvent, enforcement of the statute transfers the risk. The *Pireno* court, upon examination of an insurance company's claims adjustment process, unequivocally stated that risk is transferred at the time the contract of insurance is entered into.

The "indispensable" first prong of the *Pireno* test has not been met in this case and, therefore, the Court must hold that the process of liquidating an insurance company and fixing the priorities of its claimants is not the "business of insurance" as that term is defined in the McCarran-Ferguson Act. Summary judgment can be granted

in favor of the United States on this ground alone. Plaintiff's assertion that it need only meet one of the three *Pireno* requirements is tenuous in light of the Court's recognition that satisfaction of the first prong of the *Pireno* test, whether the challenged statute facilitates the transfer or spread of risk, is overwhelmingly important. Though the Supreme Court did not make it perfectly clear as to whether all three requirements must be satisfied,[10] the Court finds that failure to show a positive relationship to underwriting and ratemaking is fatal.

In any event, the last two prongs of the *Pireno* test have not been met. The Court finds that neither the liquidation statute nor the priority statute are an "integral part" of the relationship between the insured and the insurer. The contractual liability to pay on a policy of insurance is obviously distinct from the question of who gets paid first. As with the claims adjustment process described in *Pireno,* the concern is whether a claim is paid, not why it is paid. *Pireno,* 458 U.S. at 132. Plaintiff contends that the priority statute does in fact determine whether a policyholder gets paid. The fallacy of plaintiff's argument is in his focus on the sufficiency of assets of the insurance company and its financial ability to pay rather than its liability for risks of loss as embodied in the contract of insurance. Whether the individual policyholder would be entitled to payment was determined when the contract was entered into; that is, when the risk was transferred, and not at the time of payment, if any. In this regard, the Court sees no difference between the claims adjustment

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[10] Of the three criteria relevant in determining whether a particular practice is part of the "business of insurance," the Supreme Court wrote, "[n]one of these criteria is necessarily determinative in itself . . . ." *Pireno,* 458 U.S. at 130. It is also clear that satisfaction of only one of the criteria is not determinative. *Pilot Life Insurance Co. v. Dedeaux,* ___ U.S. ___, 107 S. Ct. 1549, 1555 (1987).

process in *Pireno* and the priority of claims for payment in the Maryland Insurance Code.

Moreover, in the process of liquidating an insurance company and providing for payment of its claimants, the entity is no longer operating as an insurance business at all. The policyholders stand on equal footing with all other claimants in their interest in getting paid. Likewise, the provision of the insurance code providing that employees' wages should be paid first does not constitute the "business of insurance."

Similarly, as to the final prong, it is clear that the liquidation of EICOM and the payment of claims involve entities outside the insurance industry.[11] It is not required that all parties involved in a challenged practice be insurance companies. *Blue Cross and Blue Shield,* 620 F. Supp. at 919. Insolvency and priority statutes, however, are not peculiar to the insurance industry. The appropriate focus of the "business of insurance" analysis is the nature of the activity itself, not the type of business that is conducting it. *Perry v. Fidelity Union Life Insurance Co.,* 606 F.2d at 470. These statutes govern the rights of all creditors, not just policyholders.

Accordingly, the liquidation of an insolvent insurance company and the priority of claims paid thereto does not constitute the "business of insurance" as that term is used in the McCarran-Ferguson Act.

Proffered policy arguments by the plaintiff do not persuade this Court to carve out an exception to the seemingly harsh results in this case.[12] The plaintiff questions

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[11] This Court has noted that this last criterion of the *Pireno* test "should be given less weight than the previous two." *Blue Cross and Blue Shield,* 620 F. Supp. at 918.

[12] Whatever the result of this case, "covered claims" of policyholders will be paid by the Property and Casualty Insurance Guaranty Corporation. It is the guaranty association, as well as policyholders of

the applicability of § 3713 itself and suggests that the original purpose underlying its enactment no longer exists. This Court is not prepared to question the validity of an almost two-hundred year old statute established for precisely the purpose of seeing that the government gets paid. *King v. United States.*, 379 U.S. 329 (1964). Moreover, the Supreme Court has instructed that the priority statute is to be construed liberally in order to effectuate this purpose.[13] *United States v. Emory,* 314 U.S. 423, 426 (1941), *citing Bramwell v. U.S. Fidelity and Guaranty Co.,* 269 U.S. 483, 487 (1926). The United States may rightfully assert its priority under § 3713. Summary judgment will be entered in favor of the defendants. Counsel for defendants shall submit an appropriate Order to the Court in conformity with this opinion within ten days.

August 31, 1987

/s/Walter E. Black, Jr.
Walter E. Black, Jr.
United States District Judge

"uncovered claims," who will bear the loss. "Covered claims" are, generally, those insurance policy contracts issued to residents of the state of Maryland or for the protection of third parties who reside in the state of Maryland. Md. Ann. Code art. 48A, § 505 (1986). The claims of the United States would not be a "covered claim."

[13] The McCarran-Ferguson Act is to be narrowly construed in face of valid federal regulatory interests. *Cochran v. Paco, Inc.,* 606 F.2d 460, 467 (5th Cir. 1979).

15 U.S.C. § 1011-5

§ 1011. Declaration of policy

Congress declares that the continued regulation and taxation by the several States of the business of insurance is in the public interest, and that silence on the part of the Congress shall not be construed to impose any barrier to the regulation or taxation of such business by the several States.

§ 1012. Regulation by State law; Federal law relating specifically to insurance; applicability of certain Federal laws after June 30, 1948

(a) The business of insurance, and every person engaged therein, shall be subject to the laws of the several States which relate to the regulation or taxation of such business.

(b) No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance, or which imposes a fee or tax upon such business, unless such Act specifically relates to the business of insurance: *Provided,* That after June 30, 1948, the Act of July 2, 1890, as amended, known as the Sherman Act, and the Act of October 15, 1914, as amended, known as the Clayton Act, and the Act of September 26, 1914, known as the Federal Trade Commission Act, as amended, shall be applicable to the business of insurance to the extent that such business is not regulated by State law.

§ 1013. Suspension until June 30, 1948, of application of certain Federal laws; Sherman Antitrust Act applicable to agreements to, or acts of, boycott, coercion, or intimidation

(a) Until June 30, 1948, the Act of July 2, 1890, as amended, known as the Sherman Act, and the Act of October 15, 1914, as amended, known as the Clayton Act, and the Act of September 26, 1914, known as the Federal

Trade Commission Act, and the Act of June 19, 1936, known as the Robinson-Patman Anti-Discrimination Act, shall not apply to the business of insurance or to acts in the conduct thereof.

(b) Nothing contained in this chapter shall render the said Sherman Act inapplicable to any agreement to boycott, coerce, or intimidate, or act of boycott, coercion, or intimidation.

§ 1014. Applicability of National Labor Relations Act and Fair Labor Standards Act of 1938

Nothing contained in this chapter shall be construed to affect in any manner the application to the business of insurance of the Act of July 5, 1935, as amended, known as the National Labor Relations Act, or the Act of June 25, 1938, as amended, known as the Fair Labor Standards Act of 1938, or the Act of June 5, 1920, known as the Merchant Marine Act, 1920.

§ 1015. Definition of "State"

As used in this chapter, the term "State" includes the several States, Alaska, Hawaii, Puerto Rico, Guam, and the District of Columbia.

31 U.S.C. § 3713

§ 3713. Priority of Government claims

(a)(1) A claim of the United States Government shall be paid first when—

(A) a person indebted to the Government is insolvent and—

(i) the debtor without enough property to pay all debts makes a voluntary assignment of property;

(ii) property of the debtor, if absent, is attached; or

(iii) an act of bankruptcy is committed; or

(B) the estate of a deceased debtor, in the custody of the executor or administrator, is not enough to pay all debts of the debtor.

(2) This subsection does not apply to a case under title 11.

(b) A representative of a person or an estate (except a trustee acting under title 11) paying any part of a debt of the person or estate before paying a claim of the Government is liable to the extent of the payment for unpaid claims of the Government.

MD. ANN. CODE art. 48A § 132-164B

§ 132. Definitions.

For the purposes of this subtitle:

(1) *"Impairment"* or *"insolvency."* The capital of a stock insurer or the surplus of a mutual or reciprocal insurer, shall be deemed to be impaired and the insurer shall be deemed to be insolvent, when such insurer is not possessed of assets at least equal to all liabilities and required reserves together with its total issued and outstanding capital stock and minimum surplus if a stock insurer, or the minimum surplus if a mutual or reciprocal insurer, required by this article to be maintained for the kind or kinds of insurance business it is then authorized to transact.

(2) *"Insurer"* means any person, firm, corporation, association or aggregation of persons doing an insurance business and subject to the insurance supervisory authority of, or to liquidation, rehabilitation, reorganization or conservation by the Commissioner or the equivalent insurance supervisory official of another state. An insurer shall also include a corporation operating a nonprofit health service plan under Subtitle 20 of this Code.

(3) *"Delinquency proceedings"* means any proceeding commenced against an insurer pursuant to this subtitle for the purpose of liquidating, rehabilitating, reorganizing or conserving such insurer.

(4) *"State"* means any state of the United States and also the District of Columbia and Puerto Rico.

(5) *"Foreign country"* means territory outside of any state.

(6) *"Domiciliary state"* means the state in which an insurer is incorporated or organized, or in the case of an insurer incorporated or organized in a foreign country, the state in which such insurer, having become authorized to do business in such state, has at the commencement of delinquency proceedings, the largest amount of its assets held in trust and assets held on deposit for the benefit of its policyholders or policyholders and creditors in the United States, and any such insurer is deemed to be domiciled in such state.

(7) *"Ancillary state"* means any state other than a domiciliary state.

(8) *"Reciprocal state"* means any state other than this State in which in substance and effect the provisions of this subtitle are in force, including the provisions requiring that the Commissioner or equivalent insurance supervisory official be the receiver of a delinquent insurer.

(9) *"General assets"* means all property, real, personal, or otherwise, not specifically mortgaged, pledged, deposited or otherwise encumbered for the security or benefit of specified persons or a limited class or classes of persons, and as to such specifically encumbered property the term includes all such property or its proceeds in excess of the amount necessary to discharge the sum or sums secured thereby. Assets held in trust and assets held on deposit for the security or benefit of all policyholders or all pol-

icyholders and creditors in the United States shall be deemed general assets.

(10) *"Preferred claim"* means any claim with respect to which the law of the State or of the United States accords priority of payments from the general assets of the insurer.

(11) *"Special deposit claim"* means any claim secured by a deposit made pursuant to statute for the security or benefit of a limited class or classes of persons, but not including any general assets.

(12) *"Secured claim"* means any claim secured by mortgage, trust deed, pledge, deposit as security, escrow or otherwise, but not including special deposit claim or claims against general assets. The term also includes claims which more than four months prior to the commencement of delinquency proceedings in the state of the insurer's domicile have become liens upon specific assets by reason of judicial process.

(13) *"Receiver"* means receiver, liquidator, rehabilitator or conservator as the context may require.

§ 133. Jurisdiction of delinquency proceedings; venue; exclusiveness of remedy; appeal; substitute conservator, rehabilitator, or receiver.

(1) The circuit courts of the counties are vested in equity with exclusive original jurisdiction of delinquency proceedings under this subtitle, and are authorized to make all necessary and proper orders to carry out the purposes of this subtitle.

(2) The venue of delinquency proceedings against a domestic insurer shall be in the county of the insurer's principal place of business. The venue of such proceedings against foreign and alien insurers shall be in Baltimore City.

(3) Delinquency proceedings pursuant to this subtitle shall constitute the sole and exclusive method of liquidating, rehabilitating, reorganizing or conserving an insurer, and no court shall entertain a petition for the commencement of such proceedings unless the same has been filed in the name of the State at the instance of the Commissioner.

(4) An appeal shall lie to the Court of Special Appeals from an order granting or refusing rehabilitation, liquidation, or conservation, and from every other order in delinquency proceedings having the character of a final order as to the particular portion of the proceedings embraced therein.

(5) On the initial application by the Commissioner for an order appointing him conservator, rehabilitator, or receiver under this subtitle, or at any time during the course of a conservatorship, rehabilitation, or receivership under this subtitle, the court, on its own motion or on the motion of the Commissioner, may issue an order appointing or substituting a person other than the Commissioner as conservator, rehabilitator, or receiver. Any person so appointed shall have the same powers and duties afforded the Commissioner under this subtitle as statutory conservator, rehabilitator, or receiver.

§ 134. Commencement of delinquency proceedings.

The Commissioner shall commence any such proceedings by application to the court for an order directing the insurer to show cause why the relief prayed for should not be granted. After a full hearing pursuant to the terms of such show-cause order, the court shall either deny the application or grant the application, together with such other relief as the nature of the case and the interests of the policyholders, creditors, stockholders, members, subscribers or the public may require.

§ 135. Injunctions.

(1) Upon application by the Commissioner for such an order to show cause, or at any time thereafter, the court may without notice issue an injunction restraining the insurer, its officers, directors, stockholders, members, subscribers, agents and all other persons from the transaction of its business or the waste or disposition of its property until the further order of the court.

(2) The court may at any time during a proceeding under this subtitle issue such injunctions or orders as may be deemed necessary to prevent interference with the Commissioner or the proceeding, or waste of the assets of the insurer, or the commencement or prosecution of any actions, or the obtaining of preferences, judgments, attachments or other liens, or the making of any levy against the insurer or against its assets or any part thereof.

(3) Notwithstanding any other provision of law, no bond shall be required of the Commissioner as a prerequisite for the issuance of any injunction or restraining order pursuant to this section.

§ 136. Grounds for rehabilitation—Domestic insurers.

The Commissioner may apply to the court for an order appointing him as receiver of and directing him to rehabilitate a domestic insurer upon one or more of the following grounds. That the insurer:

(1) Is impaired or insolvent;

(2) Has refused to submit any of its books, records, accounts or affairs to reasonable examination by the Commissioner, his deputy or examiner;

(3) Has concealed or removed records or assets;

(4) Has failed to comply with an order of the Commissioner to make good an impairment of capital or surplus or both;

(5) Has transferred or attempted to transfer substantially its entire property or business, or has entered into any transaction the effect of which is to merge substantially its entire property or business in that of any other insurer without having first obtained the written approval of the Commissioner;

(6) Has wilfully violated its charter or articles of incorporation or any law of this State;

(7) Has an officer, director or manager who has refused to be examined under oath concerning its affairs;

(8) Has been or is the subject of an application for the appointment of a receiver, trustee, custodian, conservator, or sequestrator of the insurer or its property otherwise than pursuant to the provisions of this article whether such appointment has actually been made or not;

(9) Has consented to such an order through a majority of its directors, stockholders, members or subscribers;

(10) Has failed to pay a final judgment rendered against it in this State upon any insurance contract issued or assumed by it, within sixty (60) days after the judgment became final or within sixty (60) days after the time for taking an appeal has expired, or within sixty (60) days after dismissal of an appeal before final termination, whichever date is the later;

(11) Is found, after examination by the Commissioner, to be in such condition that its further transaction of business will be hazardous to its policyholders, bondholders, or to creditors or to the public.

§ 137. Grounds for liquidation—Domestic and alien insurers.

The Commissioner may apply to the court for an order appointing him as receiver (if his appointment as receiver shall not be then in effect) and directing him to liquidate the business of a domestic insurer or of the United States

branch of an alien insurer having trusteed assets in this State, regardless of whether or not there has been a prior order directing him to rehabilitate such insurer if such insurer:

(1) Has ceased transacting business for a period of one year; or

(2) Is an insolvent insurer and has commenced voluntary liquidation or dissolution, or attempts to commence or prosecute any action or proceeding to liquidate its business or affairs, or to dissolve its corporate charter, or to procure the appointment of a receiver, trustee, custodian or sequestrator under any law except this article; or

(3) Is conducting business in a fraudulent manner; or

(4) Is in such condition that further efforts to rehabilitate the insurer, upon any of the grounds specified in § 136 of this subtitle, appear to be futile.

§ 138. Grounds for conservation—Foreign insurers.

The Commissioner may apply to the court for an order appointing him as receiver or ancillary receiver, and directing him to conserve the assets within this State, of a foreign insurer upon any of the following grounds:

(1) Upon any of the grounds specified in § 136 or 137 of this subtitle or

(2) Upon the ground that is property has been sequestrated in its domiciliary sovereignty or in any other sovereignty.

§ 139. Same—Alien insurers.

The Commissioner may apply to the court for an order appointing him as receiver or ancillary receiver, and directing him to conserve the assets within this State, of any alien insurer upon any of the following grounds:

(1) Upon any of the grounds specified in § 136 or 137 of this subtitle;

(2) Upon the ground that the insurer has failed to comply, within the time designated by the Commissioner, with an order made by him to make good an impairment of its trusteed funds; or

(3) Upon the ground that the property of the insurer has been sequestrated in its domiciliary sovereignty or elsewhere.

§ 140. Grounds for ancillary liquidation—Foreign insurers.

The Commissioner may apply to the court for an order appointing him as ancillary receiver of and directing him to liquidate the business of a foreign insurer having assets, business or claims in this State upon the appointment in the domiciliary state of such insurer of a receiver, liquidator, conservator, rehabilitator or other officer by whatever name called for the purpose of liquidating the business of such insurer.

§ 141. Order of rehabilitation; termination of rehabilitation proceedings.

(1) An order to rehabilitate a domestic insurer shall direct the Commissioner forthwith to take possession of the property of the insurer and to conduct the business thereof, and to take such steps toward removal of the causes and conditions which have made rehabilitation necessary as the court may direct.

(2) If at any time the Commissioner deems that further efforts to rehabilitate the insurer would be useless, he may apply to the court for an order of liquidation.

(3) The Commissioner, or any interested person upon due notice to the Commissioner, at any time may apply to the court for an order terminating the rehabilitation proceedings and permitting the insurer to resume possession of its property and the conduct of its business, but no such order shall be made or entered except when, after

a hearing, the court has determined that the purposes of the proceeding have been fully accomplished.

§ 142. Order of liquidation and order of dissolution—Domestic insurers.

(1) An order to liquidate the business of a domestic insurer shall direct the Commissioner forthwith to take possession of the property of the insurer, to liquidate its business, to deal with the insurer's property and business in his own name as Commissioner or in the name of the insurer, as the court may direct, and to give notice to all creditors who may have claims against the insurer to present such claims.

(2) The Commissioner may apply for and secure an order dissolving the corporate existence of a domestic insurer upon his application for an order of liquidation of such insurer or at any time after such order has been granted.

§ 143. Order of liquidation—Alien insurers.

An order to liquidate the business of a United States branch of an alien insurer having trusteed assets in this State shall be in the same terms as those prescribed for domestic insurers, save and except only that the assets of the business of such United States branch shall be the only assets included therein.

§ 144. Order of conservation or ancillary liquidation of foreign or alien insurers.

(1) An order to conserve the assets of a foreign or alien insurer shall require the Commissioner forthwith to take possession of the property of the insurer within this State and to conserve it, subject to the further direction of the court.

(2) An order to liquidate the assets in this State of a foreign insurer shall require the commissioner forthwith to take possession of the property of the insurer within

this State and to liquidate it subject to the orders of the court and with due regard to the rights and powers of the domiciliary receiver, as provided in this subtitle.

§ 145. Conduct of delinquency proceedings against domestic and alien insurers.

(1) *Appointment of Commissioner as receiver.*—Whenever under this subtitle a receiver is to be appointed in delinquency proceedings for a domestic or alien insurer, the court shall appoint the Commissioner as such receiver. The court shall order the Commissioner forthwith to take possession of the assets of the insurer and to administer the same under the orders of the court.

(2) *Title of Commissioner to assets of insurer.*—As a domiciliary receiver, the Commissioner shall be vested by operation of law with the title to all of the property, contracts and rights of action, and all of the books and records of the insurer, wherever located, as of the date of entry of the order directing him to rehabilitate or liquidate a domestic insurer or to liquidate the United States branch of an alien insurer domiciled in this State, and he shall have the right to recover the same and reduce the same to possession; except that ancillary receivers in reciprocal states shall have, as to assets located in their respective states, the rights and powers which are herein prescribed for ancillary receivers appointed in this State.

(3) *Recording of order directing possession to be taken.*—The filing or recording of the order directing possession to be taken, or a certified copy thereof, in any office where instruments affecting title to property are required to be filed or recorded shall impart the same notice as would be imparted by a deed, bill of sale, or other evidence of title duly filed or recorded.

(4) *Commissioner responsible for administration of assets: bond.*—The Commissioner as domiciliary receiver shall be responsible for the proper administration of all assets

coming into his possession or control. The court may at any time require a bond from him or his deputy if deemed desirable for the protection of such assets.

(5) *Duties of receiver upon taking possession of assets.*—Upon taking possession of the assets of an insurer, the domiciliary receiver shall, subject to the direction of the court, immediately proceed to conduct the business of the insurer or to take such steps as are authorized by this subtitle for the purpose of rehabilitating, liquidating or conserving the affairs or assets of the insurer.

(6) *Deputy commissioners and other personnel.*—In connection with delinquency proceedings, the Commissioner may appoint one or more special deputy commissioners to act for him and he may employ such counsel, clerks and assistants as he deems necessary. The compensation of the special deputies, counsel, clerks or assistants and all expenses of taking possession of the insurer and of conducting the proceedings shall be fixed by the receiver, subject to the approval of the court, and shall be paid out of the funds or assets of the insurer. Within the limits of duties imposed upon them, special deputies shall possess all the powers given to and, in the exercise of those powers, shall be subject to all of the duties imposed upon the receiver with respect to such proceedings.

§ 146. Conduct of delinquency proceedings against foreign insurers.

(1) *Appointment of Commissioner as ancillary receiver.*—Whenever under this subtitle an ancillary receiver is to be appointed in delinquency proceedings for an insurer not domiciled in this State, the court shall appoint the Commissioner as ancillary receiver. The Commissioner shall file a petition requesting the appointment on the grounds set forth in § 140 of this subtitle:

(i) If he finds that there are sufficient assets of the insurer located in this State to justify the appointment of an ancillary receiver; or

(ii) If ten or more persons resident in this State having claims against such insurer file a petition with the Commissioner requesting the appointment of such ancillary receiver.

(2) *Rights, powers and duties of domiciliary and ancillary receivers.*—The domiciliary receiver for the purpose of liquidating an insurer domiciled in a reciprocal state shall be vested by operation of law with the title to all of the property, contracts and rights of action, and all of the books and records of the insurer located in this State, and he shall have the immediate right to recover balances due from local agents and to obtain possession of any books and records of the insurer found in this State. He shall also be entitled to recover the other assets of the insurer located in this State, except that upon the appointment of an ancillary receiver in this State, the ancillary receiver shall during the ancillary receivership proceedings have the sole right to recover such other assets. The ancillary receiver shall, as soon as practicable, liquidate from their respective securities those special deposit claims and secured claims which are proved and allowed in the ancillary proceedings in this State, and shall pay the necessary expenses of the proceedings. All remaining assets he shall promptly transfer to the domiciliary receiver. Subject to the foregoing provisions, the ancillary receiver and his deputies shall have the same powers and be subject to the same duties with respect to the administration of such assets as a receiver of an insurer domiciled in this State.

(3) *Suits by domiciliary receiver.*—The domiciliary receiver of an insurer domiciled in a reciprocal state may sue in this State to recover any assets of such insurer to which he may be entitled under the laws of this State.

§ 147. Claims of nonresidents against domestic insurers.

(1) *Filing of claims.*—In a delinquency proceeding begun in this State against a domestic insurer, claimants residing

in reciprocal states may file claims either with the ancillary receivers, if any, in their respective states, or with the domiciliary receiver. All such claims must be filed on or before the last date fixed for the filing of claims in the domiciliary delinquency proceedings.

(2) *Proof of claims.*—Controverted claims belonging to claimants residing in reciprocal states may either:

(i) Be proved in this State; or

(ii) If ancillary proceedings have been commenced in such reciprocal states, may be proved in those proceedings. In the event a claimant elects to prove his claim in ancillary proceedings, if notice of the claim and opportunity to appear and be heard is afforded the domiciliary receiver of this State, as provided in § 148 of this subtitle with respect to ancillary proceedings in this State, the final allowance of such claim by the courts in the ancillary state shall be accepted in this State as conclusive as to its amount and shall also be accepted as conclusive as to its priority, if any, against special deposits or other security located within the ancillary state.

§ 148. Claims of residents of this State against foreign insurers.

(1) *Filing of claims.*—In a delinquency proceeding in a reciprocal state against an insurer domiciled in that state, claimants against such insurer who reside within this State may file claims either with the ancillary receiver, if any, appointed in this State, or with the domiciliary receiver. All such claims must be filed on or before the last date fixed for the filing of claims in the domiciliary delinquency proceedings.

(2) *Proof of claims.*—Controverted claims belonging to claimants residing in this State may either:

(i) Be proved in the domiciliary state as provided by the law of that state; or

(ii) If ancillary proceedings have been commenced in this State, be proved in those proceedings. In the event that any such claimant elects to prove his claim in this State, he shall file his claim with the ancillary receiver and shall give notice in writing to the receiver in the domiciliary state, either by certified mail, return receipt requested, bearing a postmark from the United States Postal Service, or by personal service at least forty days prior to the date set for hearing. The notice shall contain a concise statement of the amount of the claim, the facts on which the claim is based, and the priorities asserted, if any. If the domiciliary receiver within thirty days after the giving of such notice shall give notice in writing to the ancillary receiver and to the claimant, either by certified mail, return receipt requested, bearing a postmark from the United States Postal Service, or by personal service, of his intention to contest such claim, he shall be entitled to appear or to be represented in any proceeding in this State involving adjudication of the claim. The final allowance of the claim by the courts of this State shall be accepted as conclusive as to its amount and shall also be accepted as conclusive as to its priority, if any, against special deposits or other security located within this State.

§ 149. Form of claim; notice; hearing; allowance or disallowance of claim.

(1) *Form of claim.*—Claimants shall set forth in reasonable detail the amount of the claim, or the basis upon which such amount can be ascertained, the facts upon which the claim is based, and the priorities asserted, if any. All such claims shall be verified by the affidavit of the claimant, or someone authorized to act on his behalf and having knowledge of the facts, and shall be supported by such documents as may be material thereto.

(2) *How and when filed.*—All claims filed in this State shall be filed with the receiver, whether domiciliary or

ancillary, in this State, on or before the last date for filing as specified in this subtitle.

(3) *Report and recommendation of receiver; notice of hearing.*—Within ten days of the receipt of any claim, or within such further period as the court may, for good cause shown, fix, the receiver shall report the claim to the court, specifying in such report his recommendation with respect to the action to be taken thereon. Upon receipt of such report, the court shall fix a time for hearing the claim and shall direct that the claimant or the receiver, as the court shall specify, shall give such notice as the court shall determine to such persons as shall appear to the court to be interested therein. All such notices shall specify the time and place of the hearing and shall concisely state the amount and nature of the claim, the priorities asserted, if any, and the recommendation of the receiver with reference thereto.

(4) *Hearing and order.*—At the hearing, all persons interested shall be entitled to appear and the court shall enter an order allowing, allowing in part, or disallowing the claim. Any such order shall be deemed to be an appealable order.

§ 150. Priority of certain claims.

(1) *Claims of residents of ancillary states.*—In a delinquency proceeding against an insurer domiciled in this State, claims owing to residents of ancillary states shall be preferred claims if like claims are preferred under the laws of this State. All such claims owing to residents or nonresidents shall be given equal priority of payment from general assets regardless of where such assets are located.

(2) *Claims against insurer domiciled in reciprocal state.*—In a delinquency proceeding against an insurer domiciled in a reciprocal state, claims owing to residents of this State shall be preferred if like claims are preferred by the laws of that state.

(3) *Special deposit claims.*—The owners of special deposit claims against an insurer for which a receiver is appointed in this or any other state shall be given priority against their several special deposits in accordance with the provisions of the statutes governing the creation and maintenance of such deposits. If there is a deficiency in any such deposit so that the claims secured thereby are not fully discharged therefrom, the claimants may share in the general assets, but such sharing shall be deferred until general creditors, and also claimants against other special deposits who have received smaller percentages from their respective special deposits, have been paid percentages of their claims equal to the percentage paid from the special deposit.

(4) *Secured claims.*—The owner of a secured claim against an insurer for which a receiver has been appointed in this or any other state may surrender his security and file his claim as a general creditor, or the claim may be discharged by resort to the security, in which case the deficiency, if any, shall be treated as a claim against the general assets of the insurer on the same basis as claims of unsecured creditors. If the amount of the deficiency has been adjudicated in ancillary proceedings as provided in this subtitle, or if it has been adjudicated by a court of competent jurisdiction in proceedings in which the domiciliary receiver has had notice and opportunity to be heard, such amounts shall be conclusive; otherwise the amount shall be determined in the delinquency proceeding in the domiciliary state.

§ 151. Attachment and garnishment of assets.

During the pendency of delinquency proceedings in this or any reciprocal state, no action or proceeding in the nature of an attachment, garnishment or execution shall be commenced or maintained in the courts of this State against the delinquent insurer or its assets. Any lien obtained or any such action or proceeding within four months

prior to the commencement of any such delinquency proceeding or at any time thereafter shall be void as against any rights arising in such delinquency proceeding.

§ 152. Sections constituting Uniform Insurers Liquidation Act; construction.

(1) Paragraphs (2) to (13) inclusive, of § 132, together with §§ 145, 146, 147, 148, 150 and 151 constitute and may be referred to as the "Uniform Insurers Liquidation Act."

(2) The Uniform Insurers Liquidation Act shall be so interpreted and construed as to effectuate its general purpose to make uniform the law of those states that enact it. To the extent that its provisions when applicable conflict with other provisions of this subtitle, the provisions of such act shall control.

§ 153. Deposit of money collected; investment in shares of savings and loan or building and loan associations.

(a) The moneys collected by the Commissioner in a proceeding under this subtitle shall be from time to time deposited in one or more State or national banks, savings banks or trust companies, and in the case of the insolvency or voluntary or involuntary liquidation of any such depository which is an institution organized and supervised under the laws of this State, such deposits shall be entitled to priority of payment on an equality with any other priority given by the banking laws of this State. The Commissioner may in his discretion deposit such moneys or any part thereof in a national bank or trust company as a trust fund.

(b) To the extent that such an investment or account is insured by the Federal Savings and Loan Insurance Corporation or by the Maryland Savings-Share Insurance Corporation, the Commissioner may invest in shares of

savings and loan associations or building and loan associations.

§ 154. Exemption from fees.

The Commissioner shall not be required to pay any fee to any public officer in this State for filing, recording, issuing a transcript or certificate or authenticating any paper or instrument pertaining to the exercise by the Commissioner of any of the powers or duties conferred upon him under this subtitle, whether or not such paper or instrument be executed by the Commissioner or his deputies, employees or attorneys of record and whether or not it is connected with the commencement of any action or proceeding by or against the Commissioner, or with the subsequent conduct of such action or proceeding.

Nothing herein contained, however, shall be taken to relieve the Commissioner or his deputy, acting as receiver, ancillary receiver, conservator, etc. pursuant to the terms of this subtitle, from the payment of all court costs out of the assets of the insurer prior to any distribution to creditors or termination of rehabilitation. In all such cases the costs, including those contained in paragraph one hereof, shall be charged in the Commissioner's accounts to the court or be paid by the insurer as a condition of termination of the proceedings, as the case may be.

§ 155. Borrowing and pledge of assets.

For the purpose of facilitating the rehabilitation, liquidation, conservation or dissolution of an insurer pursuant to this subtitle, the Commissioner may, subject to the approval of the court, borrow money and execute, acknowledge and deliver the notes or other evidences of indebtedness therefor and secure the repayment of the same by the mortgage, pledge, assignment, transfer in trust, or hypothecation of any or all of the property, whether real, personal or mixed, of such insurer, and the Commissioner subject to the approval of the court shall

have power to take any and all other action necessary and proper to consummate any such loan and to provide for the repayment thereof. The Commissioner shall be under no obligation personally or in his official capacity to repay any loan made pursuant to this section.

§ 156. Date rights fixed on liquidation.

The rights and liabilities of the insurer and of its creditors, policyholders, stockholders, members, subscribers and all other persons interested in its estate shall, unless otherwise directed by the court, be fixed as of the date on which the order directing the liquidation of the insurer is filed in the office of the clerk of the court which made the order, subject to the provisions of this subtitle with respect to the rights of claimants holding contingent claims.

§ 157. Voidable transfers.

(1) *Certain transfers voidable.*—Any transfer of, or lien upon, the property of an insurer which is made or created within four months prior to the granting of an order to show cause under this subtitle with the intent of giving to any creditor a preference or of enabling him to obtain a greater percentage of his debt than any other creditor of the same class and which is accepted by such creditor having reasonable cause to believe that such preference will occur, shall be voidable.

(2) *Liability of persons concerned in such transfers.*—Every director, officer, employee, stockholder, member, subscriber and any other person acting on behalf of such insurer who shall be concerned in any such act or deed and every person receiving thereby any property of such insurer or the benefit thereof shall be personally liable therefor and shall be bound to account to the Commissioner.

(3) *Avoidance of transfer and recovery of property or its value.*—The Commissioner as receiver in any proceeding under this subtitle may avoid any transfer of or lien upon

the property of an insurer which any creditor, stockholder, subscriber or member of such insurer might have avoided and may recover the property so transferred unless such person was a bona fide holder for value prior to the date of the entering of an order to show cause under this subtitle. Such property or its value may be recovered from anyone who has received it except a bona fide holder for value as herein specified.

§ 158. Priority of claims for compensation.

(a) Compensation actually owing to officers and employees of an insurer, for services rendered within three months prior to the commencement of a proceeding against the insurer under this subtitle, but not exceeding five hundred dollars ($500) for each officer or employee, shall be paid prior to the payment of any other debt or claim, and in the discretion of the Commissioner may be paid as soon as practicable after the proceeding has been commenced; except that at all times the Commissioner shall reserve such funds as will in his opinion be sufficient for the expenses of administration.

(b) Such priority shall be in lieu of any other similar priority which may be authorized by law as to wages or compensation of such employees.

§ 158A. Priority of claims other than administration expenses, wages and taxes.

Claims by policyholders, beneficiaries, and insureds arising from and within the coverage of and not in excess of the applicable limits of insurance policies and insurance contracts issued by the company, and liability claims against insureds which claims are within the coverage of and not in excess of the applicable limits of insurance policies and insurance contracts issued by the company, and claims of the Property and Casualty Insurance Guaranty Corporation and the Maryland Life and Health Insurance Guaranty Association and any similar organization

in another state shall have priority in a liquidation proceeding over all other claims except those for expenses of administration, wages covered by § 158 and taxes.

§ 159. Offsets.

(a) In all cases of mutual debts and credits between the insurer and another person in connection with any action or proceeding under this subtitle, such debts and credits shall be set off and the balance only shall be allowed or paid, except as provided in subsection (b) below.

(b) No offset shall be allowed in favor of any such person where:

(1) The obligation of the insurer to such person would not at the date of the entry of any liquidation order or otherwise, as provided in § 156, entitle him to share as a claimant in the assets of the insurer; or

(2) The obligation of the insurer to such person was purchased by or transferred to such person with a view of its being used as an offset; or

(3) The obligation of such person is to pay an assessment levied against the members of a mutual insurer, or against the subscribers of a reciprocal insurer, or is to pay a balance upon the subscription to the capital stock of a stock insurer.

§ 160. Allowance of certain claims.

(a) *Contingent and unliquidated claims generally.*—No contingent and unliquidated claim shall share in a distribution of the assets of an insurer which has been adjudicated to be insolvent by an order made pursuant to this subtitle, except that such claim shall be considered, if properly presented, and may be allowed to share where:

(1) Such claim becomes absolute against the insurer on or before the last day for filing claims against the assets of such insurer; or

(2) There is a surplus and the liquidation is thereafter conducted upon the basis that such insurer is solvent.

(b) *Claims under liability insurance policies.*—Where an insurer has been so adjudicated to be insolvent any person who has a cause of action against an insured of such insurer under a liability insurance policy issued by such insurer shall have the right to file a claim in the liquidation proceeding, regardless of the fact that such claim may be contingent, and such claim may be allowed:

(1) If it may be reasonably inferred from the proof presented upon such claim that such person would be able to obtain a judgment upon such cause of action against such insured; and

(2) If such person shall furnish suitable proof, unless the court for good cause shown shall otherwise direct, that no further valid claim against such insurer arising out of his cause of action other than those already presented can be made; and

(3) If the total liability of such insurer to all claimants arising out of the same act of its insured shall be no greater than its maximum liability would be were it not in liquidation.

(c) *Same—Certain judgments against insured not taken as evidence of liability.*—No judgment against such an insured taken after the date of entry of the liquidation order shall be considered in the liquidation proceedings as evidence of liability, or of the amount of damages, and no judgment against an insured taken by default, or by collusion prior to the entry of the liquidation order shall be considered as conclusive evidence in the liquidation proceedings, either of the liability of such insured to such person upon such cause of action or of the amount of damages to which such person is therein entitled.

(d) *Claims of secured claimants.*—No claim of any secured claimant shall be allowed at a sum greater than the

difference between the value of the claim without security and the value of the security itself as of the date of the entry of the order of liquidation or such other date set by the court for determining rights and liabilities as provided in § 156 unless the claimant shall surrender his security to the Commissioner, in which event the claim shall be allowed in the full amount for which it is valued.

§ 161. Order of insolvency; time for filing claims after entry of such order.

(a) If upon the entry of an order of liquidation under this subtitle or at any time thereafter during liquidation proceedings the insurer shall not be clearly solvent, the court shall, upon hearing after such notice it deems proper, make and enter an order adjudging the insurer to be insolvent.

(b) After the entry of the order of insolvency, regardless of any prior notice that may have been given to creditors, the Commissioner shall notify all persons who may have claims against such insurer to file such claims with him, at a place and within the time specified in the notice, or that such claims shall be forever barred. The time specified in the notice shall be as fixed by the court for filing of claims and which shall be not less than six (6) months after the entry of the order of insolvency. The notice shall be given in such manner and for such reasonable period of time as may be ordered by the court.

§ 162. Report of Commissioner and petition for assessment.

Within three years after the date of the entry of an order of rehabilitation or liquidation of a domestic mutual insurer or a domestic reciprocal insurer, the Commissioner may take and file his report and petition to the court setting forth:

(a) The reasonable value of the assets of the insurer;

(b) The liabilities of the insurer to the extent thus far ascertained by the Commissioner;

(c) The aggregate amount of the assessment, if any, as provided in § 260 (a), which the Commissioner deems reasonably necessary to pay all claims, the costs and expenses of the collection of the assessments and the costs and expenses of the delinquency proceedings in full;

(d) Any other information relative to the affairs or property of the insurer that the Commissioner deems material.

§ 162A. Disbursement of assets to insurance guaranty associations.

(a) *Application for approval of proposal to disburse.*—Within 120 days of a final determination of insolvency of a company by a court of competent jurisdiction of this State, the Commissioner as receiver shall make application to the court for approval of a proposal to disburse unsecured assets out of the company's marshalled assets, from time to time as such assets become available, to the Property and Casualty Insurance Guaranty Corporation and the Maryland Life and Health Insurance Guaranty Association and to any similar organization in another state. (The Property and Casualty Insurance Guaranty Corporation and the Maryland Life and Health Guaranty Association and any similar organizations in other states shall hereinafter be referred to collectively as the "associations.")

(b) *Required provisions in proposal.*—The proposal shall at least include provision for:

(1) Adequate cash reserves for the payment of the expenses of administration and priority claims;

(2) Disbursements of the assets marshalled to date and subsequent disbursements of assets as they become available;

(3) Equitable allocation of disbursements to each of the associations entitled thereto; and

(4) The securing by the Commissioner from each of the associations entitled to disbursements pursuant to this section and agreement to return to the Commissioner such assets previously disbursed as may be required to pay claims of secured creditors and claims falling within the priorities established in § 158 (a) of this article in accordance with the priorities. No bond shall be required of any association.

(c) *Amount of disbursements.*—The Commissioner's proposal shall provide for disbursements to the associations in amounts at least equal to the payments made or to be made thereby for which these associations could assert claims against the Commissioner, and shall further provide that if the assets available for disbursement from time to time do not equal or exceed the amount of the payments made or to be made by the associations then disbursements shall be in the amount of available assets.

(d) *Notice to associations.*—Notice of the application shall be given to the associations in and to the commissioners of insurance of each of the states. Any notice shall be deemed to have been given when deposited in the United States certified mails, first-class postage prepaid, at least 30 days prior to submission of such application to the court. Action on the application may be taken by the court provided the above required notice has been given and provided further that the Commissioner's proposal complies with subsection (b) (1) and (b) (4).

§ 163. Order and levy of assessment.

(a) *Order of assessment.*—Upon the filing and reading of the report and petition provided for in § 162, the court, ex parte, may order the Commissioner to assess all members or subscribers of the insurer who may be subject to such an assessment, in such an aggregate amount as the court finds reasonably necessary to pay all valid claims as may be timely filed and proved in the delinquency proceedings, together with the costs and expenses of levying

and collecting assessments and the costs and expenses of the delinquency proceedings in full. Any such order shall require the Commissioner to assess each such member or subscriber for his proportion of the aggregate assessment, according to such reasonable classification of such members or subscribers and formula as may be made by the Commissioner and approved by the court.

(b) *Additional assessments.*—The court may order additional assessments to all members or subscribers of the insurer who may be subject to such an assessment, upon the filing and reading of any amendment or supplement to the report and petition referred to in subsection (a) above, if such amendment or supplement is filed within three (3) years after the date of the entry of the order of rehabilitation or liquidation.

(c) *Commissioner to levy assessment in accordance with order.*—After the entry of the order to levy and assess members or subscribers of an insurer referred to in (a) or (b) above, the Commissioner shall levy and assess members or subscribers in accordance with the order.

(d) *Maximum total assessments.*—The total of all assessments against any member or subscriber with respect to any policy, whether levied pursuant to this subtitle or pursuant to any other provision of this article, shall be for no greater amount than that specified in the policy or polices of the member or subscriber and as limited under this article.

(e) *No assessment with respect to nonassessable policy.*—No assessment shall be levied against any member or subscriber with respect to any nonassessable policy issued in accordance with this article.

§ 164. Assessment prima facie correct; notice; payment; proceedings to collect.

(a) *Assessment prima facie correct.*—Any assessment of a subscriber or member of an insurer made by the Com-

missioner pursuant to the order of court fixing the aggregate amount of the assessment against all members or subscribers and approving the classification and formula made by the Commissioner under § 163 shall be prima facie correct.

(b) *Notice.*—Each member or subscriber shall be notified of the amount of assessment to be paid by him by written notice mailed to the address of the member or subscriber last of record with the insurer. Failure of the member or subscriber to receive the notice so mailed, within the time specified therein for the payment of the assessment or at all, shall be no defense in any proceeding to collect the assessment.

(c) *Commencement of proceedings to collect.*—If any such member or subscriber fails to pay the assessment within the period specified in the notice, which period shall not be less than twenty (20) days after mailing, the Commissioner may obtain an order in the delinquency proceedings requiring the member or subscriber to show cause at a time and place fixed by the court why judgment should not be entered against such member or subscriber for the amount of the assessment together with all costs, and a copy of the order and a copy of the petition therefor shall be served upon the member or subscriber within the time and in the manner designated in the order.

(d) *Judgment in proceedings to collect.*—If the subscriber or member after due service of a copy of the order and petition referred to in (c) above is made upon him:

(1) Fails to appear at the time and place specified in the order, judgment shall be entered against him as prayed for in the petition; or

(2) Appears in the manner and form required by law in response to the order, the court shall hear and determine the matter and enter a judgment in accordance with its decision.

(e) *Collection by other means.*—The Commissioner may collect any such assessment through any other lawful means.

§ 164A. Notice of delinquency proceedings to be given to policyholders.

The receiver or conservator of any company against which delinquency proceedings are instituted under this subtitle shall within fifteen (15) days after his appointment as receiver or conservator notify each policyholder of the company by letter or such other means as the circuit courts may approve of the institution of the delinquency proceedings and of the possibility of the future cancellation of his insurance.

§ 164B. Immunity in receivership proceedings.

(a) *Certain officers immuned from liability.*—No claim of any nature whatsoever that is directly related to the receivership of an insurer shall arise against, and no liability shall be imposed upon, the Insurance Commissioner, Deputy Commissioner, Special Deputy Commissioner, or any person or entity acting as a receiver of an insurer, including surety, in rehabilitation, liquidation, or conservation as a result of a court order issued on or after January 1, 1985 for any statement made or actions taken or not taken in the good faith exercise of their powers under law. However this immunity shall not extend to acts or omissions which are malicious or grossly negligent. This qualified immunity extends to agents and employees of the receiver.

(b) *Representation of special deputy commissioners*—In any civil proceeding filed against a Special Deputy Commissioner appointed pursuant to this subtitle, the Special Deputy Commissioner shall be entitled to representation by the Attorney General in accordance with § 12-304 through § 12-312 of the State Government Article.

MD. ANN. CODE art. 48A § 504-19

§ 504. Purposes and scope of subtitle.

(a) *Purpose.*—(1) The purposes of this subtitle are to provide a mechanism for the prompt payment of covered claims under certain insurance policies and to avoid financial loss to residents of Maryland who are claimants or policyholders of an insurer, including surety, which has become insolvent; and to provide for the assessment of the cost of such payments and protection among insurers.

(2) All provisions of this subtitle shall apply to any insurer insolvency, including surety, existing as of January 1, 1985.

(b) *Scope.*—This subtitle shall apply to all kinds of direct insurance, except life insurance, health insurance, and annuities. On July 1, 1975 all of the assets and obligations of every type and description of the Motor Vehicle Security Fund as of the close of business on June 30, 1975 shall be transferred to the Property and Casualty Insurance Guaranty Corporation and administered through the appropriate account under § 506 of this subtitle. On July 1, 1981, all the assets and obligations of every type and description of the Workmen's Compensation Insolvency Fund at the close of business on June 30, 1981 shall be transferred to the Property and Casualty Insurance Guaranty Corporation and administered through the appropriate account under § 506 of this subtitle.

§ 505. Definitions.

As used in this subtitle:

(a) *"Account"* means any one of the four accounts created by § 506 of this subtitle.

(b) *"Association"* means the Property and Casualty Insurance Guaranty Corporation created under § 506 of this subtitle.

(c) (1) *"Covered claims"* means obligations, including unearned premiums, of an insolvent insurer which:

(i) 1. Arise out of the insurance policy contracts of the insolvent insurer issued to residents of this State or which are payable to residents of this State on behalf of insureds of the insolvent insurer; or

2. Arise out of surety bonds issued by the insolvent insurer for the protection of third parties, who are residents of this State;

(ii) Were unpaid by the insolvent insurer;

(iii) Are presented as a claim to the receiver in this State or the Association on or before the last date fixed for the filing of claims in the domiciliary delinquency proceedings;

(iv) 1. Except for surety bond claims, were incurred or existed prior to, on, or within 30 days after the determination of insolvency; or

2. For surety bond claims arising under surety bonds issued by a domestic insurer were incurred or existed prior to, on, or within 18 months after the determination of insolvency, whether or not the surety bonds are issued for no stated period or for a stated period; and

(v) Arise out of policy contracts or surety bonds of the insolvent insurer issued for the kinds of insurance to which this subtitle applies.

(2) "Covered claim" does not include any amount due any reinsurer, insurer, insurance pool, or underwriting association, as subrogation recoveries or otherwise. No insurer shall assert a claim of subrogation against an insured of an insolvent insurance company but may assert any claim it may have against the receiver of the insolvent insurance company.

(d) *"Insolvent insurer"* means:

(1) An insurer authorized to transact insurance or authorized to issue surety bonds in this State either at the time the policy or surety bond was issued or when the event giving rise to the claim occurred; and

(2) Against whom a final order of liquidation, with a finding of insolvency, has been entered by a court of competent jurisdiction in the state of domicile of the insurer.

(e) (1) *"Member insurer"* means any insurer which:

(i) Writes any kind of insurance to which this subtitle applies under § 504 of this subtitle including the exchange of reciprocal or interinsurance contracts; and

(ii) Is licensed to transact insurance in this State.

(2) "Member insurer" includes the Maryland Automobile Insurance Fund.

(f) (1) *"Net direct written premiums"* means direct gross premiums written in this State on insurance policies or surety bonds to which this subtitle applies, less return premiums thereon and dividends paid or credited to policyholders, or principals or obligees of surety bonds on such direct business.

(2) "Net direct written premiums" does not include premiums on contracts between insurers or reinsurers, or premiums received by insurers under the Maryland Property Insurance Availability Act.

(g) (1) *"Surety bond"*, *"surety"*, and *"suretyship"* mean insurance that guarantees the performance of contracts, other than insurance policies, and guarantee and execute bonds, undertakings, and contracts of suretyship.

(2) "Surety bond", "surety", and "suretyship" do not include mortgage guaranty, financial guaranty, or other forms of insurance offering protection against investment risks.

(h) *"Resident"* means:

(l) An individual domiciled in this State;

(2) In the case of a corporation or other entity that is not a natural person, a corporation or entity whose principal place of business is in this State.

§ 506. Corporation created; membership; division into separate accounts.

(a) *Creation.*—There is created a private, nonprofit, nonstock corporation which shall be known as the Property and Casualty Insurance Guaranty Corporation.

(b) *Members.*—All insurers defined as member insurers in § 505 (e) of this subtitle shall be and remain members of the Corporation as a condition of their authority to transact insurance in this State.

(c) *Plan of operation: directors.*—The Corporation shall perform its functions under a plan of operation established and approved under § 509 of this subtitle and shall exercise its powers through a board of directors established under § 507 of this subtitle.

(d) *Accounts.*—For purposes of administration and assessment, the Corporation shall be divided into four separate accounts: (1) the title insurance account; (2) the motor vehicle insurance account; (3) the workmen's compensation account; and (4) the account for all other insurance to which this subtitle applies.

(e) *Powers, privileges and immunities of corporation.*—Except as otherwise provided in this subtitle, the Corporation has all the powers, privileges, and immunities including perpetual existence, granted by the applicable provisions of the Corporations and Associations Article.

(f) *Corporation not deemed department, unit, agency, etc. of State.*—The Corporation is not and may not be deemed a department, unit, agency, or instrumentality of the State for any purpose. All debts, claims, obligations, and liabilities of the Corporation, whenever incurred, shall be the

debts, claims, obligations, and liabilities of the Corporation only and not of the State, its agencies, instrumentalities, officers, or employees. The Corporation moneys may not be considered part of the General Fund of the State. The State may not budget for or provide General Fund appropriations to the Corporation, and the debts, claims, obligations, and liabilities of the Corporation may not be considered to be a debt of the State or a pledge of its credit.

§ 507. Board of directors.

(a) *Composition; appointment and terms of members; chairman; vacancies.*—The board of directors of the Corporation shall consist of not less than five nor more than nine persons serving terms as established in the plan of operation. The members of the board shall be elected from member insurers. Vacancies of the board shall be filled for the remaining period of the term by a majority vote of the remaining members of the board. A chairman shall be elected by the board from its members. The board may elect officers and shall appoint an executive committee of three from its members.

(b) *Fair representation of member insurers.*—In electing directors or filling vacancies on the board, consideration shall be given to, among other things, whether all member insurers are fairly represented.

(c) *Reimbursement for expenses.*—Members of the board may be reimbursed from the assets of the Corporation for expenses incurred by them as members of the board of directors.

§ 508. Powers and duties of Corporation.

(a) The Corporation shall:

(1) (i) Except as to surety bonds, be obligated to the extent of the covered claims existing prior to the determination of insolvency and arising within 30 days after

the determination of insolvency, or before the policy expiration date if less than 30 days after the determination, or before the insured replaces the policy or causes its cancellation, if he does so within 30 days of the determination, but such obligation shall include only that amount of each covered claim which is in excess of $100 and less than $300,000. However, the Association shall pay the full amount of any covered claim arising out of a workmen's compensation policy. In no event shall the Corporation be obligated to a policyholder or claimant in an amount in excess of the obligation of the insolvent insurer under the policy from which the claim arises.

(ii) With respect to surety bonds, be obligated to the extent of the covered claims existing prior to the determination of insolvency, and arising within 18 months after the determination of insolvency whether or not the surety bonds are issued with no stated period or for a stated period. Such obligation shall include only that amount of each covered claim payable to each claimant which is in excess of $100 and less than $300,000. In no event shall the Association be liable for an aggregate amount in excess of $1,000,000 under any one bond. In the event covered claims are in excess of $1,000,000 under any one bond, the Association shall make a prorated payment on account of each covered claim in the ratio that the covered claim bears to the total amount of all covered claims under the bond. In no event shall the Association be obligated to any claimants in an amount in excess of the obligation of the insolvent insurer under the surety bond from which the claim arises.

(2) Be deemed the insurer to the extent of its obligation on the covered claims and to such extent shall have all rights, duties, and obligations of the insolvent insurer as if the insurer had not become insolvent.

(3) Allocate claims paid and expenses incurred among the four accounts separately, and assess member insurers

separately for each account in amounts necessary to pay the obligation of the Corporation under paragraph (1) of this subsection subsequent to an insolvency, the expenses of handling covered claims subsequent to an insolvency, and other expenses authorized by this subtitle. The assessments of each member insurer shall be in the proportion that the net direct written premiums of the member insurer for the preceding calendar year on the kinds of insurance in the account bears to the net direct written premiums of all member insurers for the preceding calendar year on the kinds of insurance in the account. Each member insurer shall be notified of the assessment not later than 30 days before it is due. No member insurer may be assessed in any year on any account in an amount greater than 2 percent of that member insurer's net direct written premiums for the preceding calendar year on the kinds of insurance in the account. If the maximum assessment, together with the other assets of the Corporation in any account, does not provide in any one year in any account an amount sufficient to make all necessary payments from that account, the funds available shall be prorated and the unpaid portion shall be paid as soon thereafter as funds become available. The Corporation may exempt or defer, in whole or in part, the assessment of any member insurer, if the assessment would cause the member insurer's financial statement to reflect amounts of capital or surplus less than the minimum amounts required for a certificate of authority by any jurisdiction in which the member insurer is authorized to transact insurance. Each member insurer may set off against any assessment, authorized payments made on covered claims and expenses incurred in the payment of such claims by the member insurer if they are chargeable to the account for which the assessment is made.

(4) Investigate claims brought against the Corporation and adjust, compromise, settle, and pay covered claims to the extent of the Corporation's obligation and deny all

other claims and may review settlements, releases and judgments to which the insolvent insurer or its insureds were parties to determine the extent to which such settlements, releases and judgments may be properly contested.

(5) Notify such persons as the Commissioner directs under § 510(b)(1) of this subtitle.

(6) Handle claims through its employees or through one or more insurers or other persons designated as servicing facilities. Designation of a servicing facility is subject to the approval of the Commissioner, but such designation may be declined by a member insurer.

(7) Reimburse each servicing facility for obligations of the Corporation paid by the facility and for expenses incurred by the facility while handling claims on behalf of the Corporation and shall pay the other expenses of the Corporation authorized by this subtitle.

(b) The Corporation may:

(1) Employ or retain such persons as are necessary to handle claims and perform other duties of the Corporation.

(2) Borrow funds necessary to effect the purposes of this subtitle in accord with the plan of operation.

(3) Sue or be sued.

(4) Negotiate and become a party to such contracts as are necessary to carry out the purpose of this subtitle.

(5) Perform such other acts as are necessary or proper to effectuate the purpose of this subtitle.

(6) Refund to the member insurers in proportion of the contribution of each member insurer to that account that amount by which the assets of the account exceed the liabilities if, at the end of any calendar year, the board of directors finds that the assets of the Corporation in

any account exceed the liabilities of that account as estimated by the board of directors for the coming year.

§ 509. Plan of operation.

(a) *Submission of plan and amendments; when effective; effect of failure to submit plan or suitable amendments.*—(1) The Corporation shall submit to the Commissioner a plan of operation and any amendments thereto necessary or suitable to assure the fair, reasonable, and equitable administration of the Corporation. The plan of operation and any amendments thereto shall become effective upon approval in writing by the Commissioner.

(2) If the Corporation fails to submit a suitable plan of operation within 90 days following July 1, 1971, or if at any time thereafter the Corporation fails to submit suitable amendment to the plan, the Commissioner shall, after notice and hearing adopt and promulgate such reasonable rules as are necessary or advisable to effectuate the provisions of this subtitle. Such rules shall continue in force until modified by the Commissioner or superseded by a plan submitted by the Corporation and approved by the Commissioner.

(b) *Compliance by member insurers.*—All member insurers shall comply with the plan of operation.

(c) *Contents of plan.*—The plan of operation shall:

(1) Establish the procedures whereby all the powers and duties of the Corporation under § 508 will be performed.

(2) Establish procedures for handling assets of the Corporation.

(3) Establish the amount and method of reimbursing members of the board of directors under § 507.

(4) Establish procedures by which claims may be filed with the Corporation and establish acceptable forms of proof of covered claims. Notice of claims to the receiver

or liquidator of the insolvent insurer shall be deemed notice to the Corporation or its agent and a list of such claims shall be periodically submitted to the Corporation by the receiver or liquidator.

(5) Establish regular places and times for meetings of the board of directors.

(6) Establish procedures for records to be kept in all financial transactions of the Corporation, its agents, and the board of directors.

(7) Provide that any member insurer aggrieved by any final action or decision of the Corporation may appeal to the Commissioner within 30 days after the action or decision.

(8) Contain additional provisions necessary or proper for the execution of the powers and duties of the Corporation.

(d) *Delegation of powers and duties of Corporation.*—The plan of operation may provide that any or all powers and duties of the Corporation except those under §§ 508 (a)(3) and 508 (b)(2), are delegated to a corporation, association, or other organization which performs or will perform functions similar to those of this Corporation, or its equivalent. Such a corporation, association or organization shall be reimbursed as a servicing facility would be reimbursed and shall be paid for its performance of the functions of the Corporation. A delegation under this subsection shall take effect only with the approval of both the board of directors and the Commissioner, and may be made only to a corporation, association, or organization which extends protection not substantially less favorable and effective than that provided by this subtitle.

§ 510. Duties and powers of Commissioner generally; review of actions or orders.

(a) The Commissioner shall:

(1) Notify the Corporation of the existence of an insolvent insurer not later than 3 days after he received notice of the determination of the insolvency.

(2) Upon request of the board of directors, provide the Corporation with a statement of the net direct written premiums of each member insurer.

(b) The Commissioner may:

(1) Require that the Corporation notify the insureds or the principal and specific obligees named in surety bonds, of the insolvent insurer and any other known interested parties of the determination of insolvency and of their rights under this subtitle. Such notifications may be by mail at their last-known address, where available, but if sufficient information for notification by mail is not available, notice by publication in a newspaper of general circulation shall be sufficient.

(2) Suspend or revoke, after notice and hearing, the certificate of authority to transact insurance in this State of any member insurer which fails to pay an assessment when due or fails to comply with the plan of operation. As an alternative, the Commissioner may levy a fine on any member insurer which fails to pay an assessment when due. Such fine shall not exceed 5% of the unpaid assessment per month, except that no fine shall be less than $100 per month.

(3) Revoke the designation of any servicing facility if he finds claims are being handled unsatisfactorily.

(c) Any final action or order of the Commissioner under this subtitle shall be subject to judicial review in a court of competent jurisdiction.

§ 511. Effect of payment of claim; statements to be filed with receiver or liquidator of insolvent insurer.

(a) *Assignment of rights; cooperation by insured or claimant; cause of action against insured; insolvent insurer operating on plan with assessment liability.*—Any person recovering under this subtitle shall be deemed to have

assigned his rights under the policy to the Corporation to the extent of his recovery from the Corporation. Every insured or claimant seeking the protection of this subtitle shall cooperate with the Corporation to the same extent as such person would have been required to cooperate with the insolvent insurer. The Corporation shall have no cause of action against the insured of the insolvent insurer for any sums it has paid out except such causes of action as the insolvent insurer would have had if such sums had been paid by the insolvent insurer. In the case of an insolvent insurer operating on a plan with assessment liability, payments of claims of the Corporation shall not operate to reduce the liability of insureds to the receiver, liquidator, or statutory successor for unpaid assessments.

(b) *Receiver, etc., of insolvent insurer bound by settlements of covered claims; priority of claims and expenses in handling claims.*—The receiver, liquidator, or statutory successor of an insolvent insurer shall be bound by settlements of covered claims by the Corporation or its representatives. The court having jurisdiction shall grant such claims priority equal to that which the claimant would have been entitled in the absence of this subtitle against the assets of the insolvent insurer. The expenses of the Corporation or similar organization in handling claims shall be accorded the same priority as the liquidator's expenses.

(c) *Statements to be filed with receiver or liquidator of insolvent insurer.*—The Corporation shall periodically file with the receiver or liquidator of the insolvent insurer statements of the covered claims paid by the Corporation and estimates of anticipated claims on the Corporation which shall preserve the rights of the Corporation against the assets of the insolvent insurer.

§ 512. Exhaustion of rights and effect of recovery under certain policies; claims recoverable from more than one corporation.

(a) Any person having a covered claim against an insurer, including surety, under any provision in an insurance policy or surety bond, other than a policy of an insolvent insurer which is also a covered claim, shall be required to exhaust first his right under such policy or bond. Any amount payable on a covered claim under this subtitle shall be reduced by the amount of any recovery under such insurance policy or surety bond.

(b) Any person having a claim which may be recovered under more than one insurance guaranty association or its equivalent shall seek recovery first:

(1) Except with respect to a surety bond, from the Corporation of the place of residence of the insured except that if it is a first party claim for damage to property with a permanent location, he shall seek recovery first from the Corporation of the location of the property;

(2) With respect to a surety bond, from the Corporation of the place of performance of the obligation described in the bond.

(c) Any recovery under this subtitle shall be reduced by the amount of recovery from any other insurance guaranty association or its equivalent.

§ 513. Detection and prevention of insolvencies.

Repealed by Acts 1986, ch. 161, § 1, effective July 1, 1986.

§ 514. Examination and regulation by Commissioner; financial report.

The Corporation shall be subject to examination and regulation by the Commissioner. The board of directors shall submit, not later than March 30 of each year, a

financial report for the preceding calendar year in a form approved by the Commissioner.

§ 515. Exemption from payment of fees and taxes.

The Corporation shall be exempt from payment of all fees and all taxes levied by this State or any of its subdivisions except taxes levied on real or personal property.

§ 516. Recoupment of assessments paid by member insurers.

The rates and premiums charged for insurance policies and surety bonds to which this subtitle applies shall include amounts sufficient to recoup over a reasonable length of time which shall not be less than three years, a sum equal to the amounts paid to the Corporation by the member insurer less any amounts returned to the member insurer by the Corporation and such rates shall not be deemed excessive because they contain an amount reasonably calculated to recoup assessments paid by the member insurer.

§ 517. Immunity from liability.

There shall be no liability on the part of and no cause of action of any nature shall arise against any member insurer, the Corporation or its agents or employees, the board of directors, or the Commissioner or his representatives for any action taken by them in the performance of their powers and duties under this subtitle. Notwithstanding the provisions of this section, the Corporation is not and may not be deemed a department, unit, agency, or instrumentality of the State.

§ 518. Stay of proceedings involving insolvent insurers; setting aside default judgment, etc.

All proceedings in which the insolvent insurer is a party or is obligated to defend a party in any court in this State shall be stayed for 60 days from the date the insolvency is determined to permit proper defense by the Corporation of all pending causes of action. As to any covered claims

arising from a judgment under any decision, verdict or finding based on the default of the insolvent insurer or its failure to defend an insured, the Corporation either on its own behalf or on behalf of such insured may apply to have such judgment, order, decision, verdict or finding set aside by the same court or administrator that made such judgment, order, decision, verdict or finding and shall be permitted to defend against such claim on the merits.

§ 519. Termination; distribution of moneys and assets; expiration of subtitle.

(a) *Termination as to certain kind of insurance—In general.*—The Commissioner shall by order terminate the operation of the Property and Casualty Insurance Guaranty Corporation as to any kind of insurance covered by this subtitle with respect to which he has found, after hearing, that there is in effect a statutory or voluntary plan which:

(1) Is a permanent plan which is adequately funded or for which adequate funding is provided; and

(2) Extends, or will extend to the Maryland policyholders and residents protection and benefits with respect to insolvent insurers not substantially less favorable and effective to such policyholders and residents than the protection and benefits provided with respect to such kinds of insurance under this subtitle.

(b) *Same—Discontinuance of future payments by insurers.*—The Commissioner shall by the same order authorize discontinuance of future payments by insurers to the Corporation with respect to the same kinds of insurance; provided, the assessments and payments shall continue, as necessary, to liquidate covered claims of insurers adjudged insolvent prior to said order and the related expenses not covered by such other plan.

(c) *Termination as to all kinds of insurance; distribution of moneys and assets; expiration of subtitle.*—In the event the operation of the Property and Casualty Insurance

Guaranty Corporation shall be so terminated as to all kinds of insurance otherwise within its scope, the Corporation as soon as possible thereafter shall distribute the balance of moneys and assets remaining (after discharge of the functions of the Corporation with respect to prior insurer insolvencies not covered by such other plan, together with related expenses) to the insurers which are then writing in this State policies of the kinds of insurance covered by this subtitle and which had made payments to the Corporation, pro rata upon the basis of the aggregate of such payments made by the respective insurers during the period of five years next preceding the date of such order. Upon completion of such distribution with respect to all of the kinds of insurance covered by this subtitle, this subtitle shall be deemed to have expired.